

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 12. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form CMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 2a Film 6106  
11/12/68 kk  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14528

1. DECEASED-NAME (Type or Print)			First Thomas			Middle Hobart			Last AINSWORTH			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year			2b. HOUR M														
3. SEX Male		4. RACE Cauc		5. DATE OF BIRTH Nov. 17, 1896		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Oct. Day 23 Year 19 68			2d. HOUR 725 P M														
7a. BIRTHPLACE (State or foreign country) New York			7b. CITIZEN OF WHAT COUNTRY? USA			B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery						Md.														
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Psychiatrist			12b. KIND OF BUSINESS OR INDUSTRY Public Health																				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Bethesda			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 5312 Hampden Lane																	
14. FATHER'S NAME George R.			First Middle Last AINSWORTH			15. MOTHER'S MAIDEN NAME GRACE			First Middle Last ABBOTT																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16b. SOCIAL SECURITY NO. 1999-40			17. INFORMANT Bethesda, Md. Mrs. Mary H. Ainsworth, 5312 Hampden Lane			ADDRESS																				
MEDICAL CERTIFICATION															18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
															PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201														
															19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
															21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			John G. Ball, M. D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED 10/25/68			Bethesda, Maryland																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10-28-68			23c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Utica, New York																				
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home 7557 Wisconsin Ave., Bethesda, Maryland						25a. REC'D BY REGISTRAR DATE NOV 4 1968			25b. REGISTRAR'S SIGNATURE Charles J. J...																				

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## REPORT

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# THE G. J. A.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

14521

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14529

1. DECEASED-NAME (Type or print) Timothy Dixon Aldredge			2a. DATE OF DEATH Month Day Year October 16 1968			2b. HOUR A 6:30 M									
3. SEX Male		4. RACE White		5. DATE OF BIRTH 17 September 1959		6. AGE (In years lost birthday) 9 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.									
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student			12b. KIND OF BUSINESS OR INDUSTRY --								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE West Virginia		13b. COUNTY Logan		13c. CITY OR TOWN Logan		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 120 Terrace Drive							
14. FATHER'S NAME First Middle Last James C. Aldredge			15. MOTHER'S MAIDEN NAME First Middle Last LaJeana Williamson			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)						16b. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2040 Bronchopneumonia, Right Middle Lobe, Resolving DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Lymphocytic Leukemia DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Weeks 5 Years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 2043															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (X) (this hospital) attended the deceased from 12 August, 1968, to 16 Oct., 1968, that (X) (we) last saw the deceased alive on 16 October 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.															
22b. SIGNATURE David H. Riddick, M.D.				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/16/68							
22d. PHYSICIAN'S NAME (Type) David H. Riddick, M. D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/19/68		23c. NAME OF CEMETERY OR CREMATORY Forrest Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Pecks Mill, Logan Co. W. Va.									
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				47557 Wisconsin Ave. ADDRESS		25a. REC'D BY REGISTRAR OCT 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge							

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14522		CERTIFICATE OF DEATH						14530			
1. DECEASED-NAME (Type or print)			First Middle Lost			2a. DATE OF DEATH Month Day Year			2b. HOUR		
BABY			GIRL			ALLEN			October 26 1968 10:04P		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
FEMALE		CAUCASIAN		25 October 1968			YRS. 1		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
MARYLAND		U.S.A.					MONTGOMERY Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA			NAVAL HOSPITAL, NMMC			N.A.			N.A.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Lost			15. MOTHER'S MAIDEN NAME First Middle Lost								
JAMES OLE ALLEN			GAIL ANN MANTER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT					
NO			NONE			361 JAMES STREET JAMES OLE ALLEN FALLS CHURCH, VA.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema associated with extensive</u>											
7720 DUE TO, OR AS A CONSEQUENCE OF <u>subarachnoid hemorrhage</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
7600											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>0239 10/25/68</u> , to <u>2204 10/26/68</u> , that (I) (we) last saw the deceased alive on <u>26 October 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE ✓ <u>G. H. SAFELY</u>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED 26 October 1968					
22d. PHYSICIAN'S NAME (Type) G. H. SAFELY, M. D.		22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10/28/68		23c. NAME OF CEMETERY OR CREMATORY MILLER CEMETERY		23d. LOCATION (City or Town) (County) (State) TEMPLE HILLSBORO N.H.					
24. FUNERAL DIRECTOR R.A. PUMPHREY 7557 WISCONSIN AVE, MARYLAND		ADDRESS BETHESDA				25a. REC'D BY REGISTRAR DATE NOV 4 1968		25b. REGISTRAR'S SIGNATURE f Charles Judge			

14830

OFFICE OF STATE

RECEIVED FROM THE SECRETARY OF THE STATE

NOV 1958

Handwritten signature and initials

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 23b Film G406 11/8/68 kk

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14523

14531

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Lucia Marguerita Amaya			2a. DATE OF DEATH Month Day Year October 30 1968			2b. HOUR P M 2:15 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH 13 December 1913		6. AGE (In years last birthday) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) El Salvador		7b. CITIZEN OF WHAT COUNTRY? El Salvador		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11513 Deborah Drive	
14. FATHER'S NAME First Middle Last Policarpio Amaya			15. MOTHER'S MAIDEN NAME First Middle Last Luisa Pineda						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None		17. INFORMANT The Medical Record Address The Clinical Center, NIH, Bethesda, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Breast</u> 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 Weeks									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 170X									
19a. DATE OF OPERATION 10/17/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of the Breast			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>14 Oct.</u> , 19 <u>68</u> , to <u>30 Oct.</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <u>30 October</u> , 19 <u>68</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE <u>Clarence H. Brown, M.D.</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/31/68			
22d. PHYSICIAN'S NAME (Type) Clarence H. Brown, M.D.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-2-1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (City or Town) (County) (State) Silver Spring, Montgomery, Md.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 2130 Wisc. Ave. N.W., Wash., D.C., 20016				25a. REC'D BY REGISTRAR DATE NOV 7 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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UNITED STATES

1. The first part of the report is a description of the work done during the year.

2. The second part of the report is a description of the work done during the year.

3. The third part of the report is a description of the work done during the year.

4. The fourth part of the report is a description of the work done during the year.

5. The fifth part of the report is a description of the work done during the year.

6. The sixth part of the report is a description of the work done during the year.

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10. The tenth part of the report is a description of the work done during the year.

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## CERTIFICATE OF DEATH

14532

1. DECEASED-NAME (Type or print) <b>MARGARET M. ANDERSON</b>		2a. DATE OF DEATH Month <b>OCTOBER</b> Day <b>3</b> Year <b>1968</b>		2b. HOUR <b>8:50P</b> M
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>7/29/83</b>		6. AGE (In years last birthday) <b>95</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOLY CROSS HOSPITAL</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>AT HOME</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>SAME</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>	13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>TAKOMA PARK</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>7713 GREENWOOD AVE</b>
14. FATHER'S NAME First <b>NOLAN</b> Middle <b>NOLAN</b> Last <b>NOLAN</b>	15. MOTHER'S MAIDEN NAME First <b>NOT AVAILABLE</b> Middle <b>NOT AVAILABLE</b> Last <b>NOT AVAILABLE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address <b>ALFRED V. ANDERSON - 7713 GREENWOOD AVE</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bleeding Peptic Ulcer of Duodenum</b> <b>5320</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>5410</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <b>Generalized Atherosclerosis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug</b> , 1968, to <b>Oct 3</b> , 1968, that (I) ( <del>we</del> ) last saw the deceased alive on <b>Oct 3</b> , 1968, and that (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.				
22b. SIGNATURE <b>Morton Aitschuler</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10-3-68</b>
22d. PHYSICIAN'S NAME (Type) <b>Morton Aitschuler, MD</b>		22e. ADDRESS <b>9205-New Hang Ave Silver Spring, Md</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct 7, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Forest Glen Silver Spring Md.</b>
24. FUNERAL DIRECTOR Address <b>Arthur Walters, 254 Carroll St NW Wash. DC</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



14532

GRAPHIC OF DEATH

1501

MANORST - M. ANDERSON - 1927

7/27/23

MONTGOMERY

NO. 213 GREENWOOD AVE. TAKOMA PARK MARY CROSS HOSPITAL

2028 COLLEGE BLVD

OCT 1 1923

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

14525

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14533

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>HARRY S. AUBINOE</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>28</b> Year <b>68</b>			2b. HOUR <b>8:30 A</b> M				
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>4-29-1882</b>		6. AGE (In years last birthday) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>So. Carolina USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery County, Md.</b>				
1d. CITY OR TOWN OF DEATH <b>Silver Spring, Md.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Sheet Metal Worker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md.</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>12150 GEORGIA AVE.</b>	
14. FATHER'S NAME First <b>Samuel</b> Middle <b>R.</b> Last <b>Aubinoe</b>			15. MOTHER'S MAIDEN NAME First <b>Annie</b> Middle <b>Spont.</b> Last <b>Spont.</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>579-03-1918</b>		17. INFORMANT Name <b>Randall S. Aubinoe</b> Address <b>Rockville, Md.</b> <b>5924 Holland Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> <b>4369</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>331X</b> (b) <b>Cerebrovascular accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8-hrs</b> <b>2 weeks</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Dividing angina</b> <b>Emphysema</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/2/68</b> , 19____, to <b>10/28/68</b> , 19____, that (I) (we) last saw the deceased alive on <b>10/27/68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Patrick C. Jamison</b> M.D. DEGREE <b>MD</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/28/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Patrick C. Jamison, M.D.</b>					22e. ADDRESS <b>11718 Georgia Silver Spring Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-31-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville Montgomery Md.</b>				
24. FUNERAL DIRECTOR <b>Warner E. Dumphrey, Inc.</b> ADDRESS <b>8434 Co. Ave. S.S. Md.</b>					25a. REC'D BY REGISTRAR <b>OCT 31 1968</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

14883

14883

Oct 1 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14526		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14534	
1. DECEASED-NAME (Type or print) <b>Martha</b>		First (NMN) <b>Awkward</b>		2a. DATE OF DEATH <b>Oct.</b> Month <b>26</b> Day <b>68</b> Year		2b. HOUR <b>12:40</b> M	
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>7-30-13</b>		6. AGE (In years last birthday) <b>55</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Montgomery General Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Sandy Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER		14. FATHER'S NAME First Middle Last <b>Wesley Marr</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Ruth Howard</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TERMINAL PULMONARY EDEMA</b> 1977 DUE TO, OR AS A CONSEQUENCE OF <b>CARCINOMATOSIS, DIFFUSE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ADENOCARCINOMA LIVER - METASTATIC</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>6 mo.</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1561</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from <b>MAY</b> , 19 <b>64</b> , to <b>OCT 26</b> , 19 <b>68</b> , that (1) (we) lost saw the deceased alive on <b>OCT 26</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Donald R. Lewis M.D.</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>OCT 27 68</b>	
22d. PHYSICIAN'S NAME (Type) <b>DONALD R. LEWIS M.D.</b>		22e. ADDRESS <b>700 CLOVERLY ST. SILVER SPR. MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10-29-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Sandy Spring Montg Md.</b>	
24. FUNERAL DIRECTOR <b>Robert L. Snowden</b>		ADDRESS <b>Rockville Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

15534

STATE OF TEXAS

15534



Technical Personnel  
Chenonathia  
Hennochowen Live - Metastatic

MAY 11 1988

OCT 11 1988

Donald R Lewis MD  
OCT 23 1988

NOV 1 1988



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Hilda Augusta Bailey</b>					2a. DATE OF DEATH Month <b>10</b> Day <b>27</b> Year <b>1968</b>			2b. HOUR <b>1:45 P.M.</b>	
3. SEX <b>female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>1-17-1894</b>		6. AGE (In years last birthday) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Washington, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Kensington Gardens N.H.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>D. C.</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5405 39th St. N.W.</b>	
14. FATHER'S NAME First <b>William</b> Middle <b>Andrews</b> Last <b>Andrews</b>			15. MOTHER'S MAIDEN NAME First <b>Isabelle</b> Middle <b>Wilson</b> Last <b>Wilson</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>579-14-7890-B</b>		17. INFORMANT Address <b>Wilson W. Bailey, Husband, same as item #1</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>433.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>15 yrs.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>332x</b> <b>h</b>									
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>-</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , 19__, to <b>10/27</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-27</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Marvin Fuchs M.D.</b>				22c. DATE SIGNED <b>10-27-68</b>		22d. PHYSICIAN'S NAME (Type) <b>MARVIN FUCHS</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-30-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>			



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
14528 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14536													
1. DECEASED-NAME (Type or Print) First Middle Last Catherine Margaret Baithis.						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year Oct 15 1968			2b. HOUR 11:30 P.M.				
3. SEX Fe-		4. RACE W-		5. DATE OF BIRTH Jan. 18 1892		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7c. DATE PRONOUNCED DEAD Month Day Year Oct. 15 1968						2d. HOUR 11:30 P.M.							
7a. BIRTHPLACE (State or foreign country) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Gaithersburg				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Asbury Methodist Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland						13b. CITY OR TOWN Strasburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last Charles Atwell McCarty				15. MOTHER'S MAIDEN NAME First Middle Last Eugenie Sommer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO. 218-54-9113				17. INFORMANT ADDRESS Gaithersburg Methodist Home Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Urinary Tract Infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arterio Sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 5 days years.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4500 Fracture of Left Hip.													
19a. DATE OF OPERATION 18 Sept 1968				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Repair of Hip Prosthesis				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 11:00 A.M. 9/14 1968				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell in running home causing fracture					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Nursing Home				21f. LOCATION Street or R.F.D. No. Gaithersburg		City or Town Montgomery		State Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John B. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Gaithersburg, Md.				22b. DATE SIGNED Oct 16, 1968					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-18-68		23c. NAME OF CEMETERY OR CREMATORY Riverview				23d. LOCATION (City or Town) (County) (State) Strasburg, Va.					
24. FUNERAL DIRECTOR Ernest C. Gartner				25a. REC'D BY REGISTRAR DATE OCT 21 1968				25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14529		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		14537	
1. DECEASED-NAME (Type or print) First Middle Last ALFREDO BANOS			2a. DATE OF DEATH Month Day Year 10 20 1968		2b. HOUR 7 <sup>05</sup> A M
3. SEX Male	4. RACE white	5. DATE OF BIRTH 3-20-1881		6. AGE (In years last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Mexico	7b. CITIZEN OF WHAT COUNTRY? MEXICO	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH MONTGOMERY		
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kensington Gardens Sanit		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) GOVERNMENT AETIC	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D.C.		13b. COUNTY Washington	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4701 Conn. Ave Apt 107
14. FATHER'S NAME First Middle Last Jose A BANOS		15. MOTHER'S MAIDEN NAME First Middle Last - CONTREROS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 578-30 7454		17. INFORMANT Address DOLORES SCHNEIDER, DAUGHTER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> 342X DUE TO, OR AS A CONSEQUENCE OF <u>Coronary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 years</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 350X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1956 to Oct 20, 1968, that (I) (we) last saw the deceased alive on Oct 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Andrew E Rudnai		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/20/68	
22d. PHYSICIAN'S NAME (Type) ANDREW E RUDNAI		22e. ADDRESS 1200 Woodlawn Bld.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-23-1968		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery	
23d. LOCATION (City or Town) (County) (State) Silver Spring, Montgomery Co.		24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016			
25a. REC'D BY REGISTRAR DATE OCT 23 1968		25b. REGISTRAR'S SIGNATURE M. J. [Signature]			



14537

CRIMINAL OF DEATH



RECEIVED  
JAN 10 1960  
FBI - NEW YORK

RECEIVED  
JAN 10 1960  
FBI - NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

14530										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14538									
1. DECEASED-NAME (Type or print) First Middle Last Theresa nmn Barick										2a. DATE OF DEATH 10 Month 2 Day 68 Year										2b. HOUR 3:28 P.M.									
3. SEX Female					4. RACE Caus.					5. DATE OF BIRTH 1/1/1892					6. AGE (In years last birthday) 76 YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) N.Y., N.Y.					7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Montgomery Md.														
10. CITY OR TOWN OF DEATH Wheaton					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife					12b. KIND OF BUSINESS OR INDUSTRY -----														
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland					13b. COUNTY Montgomery					13c. CITY OR TOWN Silver Spring					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 10613 Cavalier Drive									
14. FATHER'S NAME First Middle Last Moses Menkes					15. MOTHER'S MAIDEN NAME First Middle Last Hannah (unknown)																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-54-1336					17. INFORMANT Rivolanne Sacks (same as 13 above)																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis &amp; hemorrhage</u> 4330 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertensive arteriosclerotic vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>332X</u>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1962</u> to <u>10-2-1968</u> , that (I) (we) last saw the deceased alive on <u>10-2-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Jason Berger M.D.</u>										DEGREE M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 10-2-68									
22d. PHYSICIAN'S NAME (Type) JASON BERGER, M.D.										22e. ADDRESS 800 PERSHING DRIVE SILVER SPRING, MD.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE Oct. 4, 1968					23c. NAME OF CEMETERY OR CREMATORY Washington Cem.					23d. LOCATION (City or Town) (County) (State) Beans, N.J.														
24. FUNERAL DIRECTOR Goldberg Fun Home										ADDRESS 435 W. 20th St. Wash D.C. 20011					25a. REC'D BY REGISTRAR DATE OCT 4 1968					25b. REGISTRAR'S SIGNATURE Charles Judge									

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CERTIFICATE OF DATA

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Eugene</b>			First <b>P.</b> Middle <b>BARRETT</b> Last			2a. DATE OF DEATH <b>Oct.</b> Month <b>31</b> Year <b>68</b>		2b. HOUR <b>P</b> <b>1253</b> M	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Aug. 7, 1934</b>		6. AGE (In years last birthday) <b>34</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Bethesda,</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>U. S. Navy</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Illinois</b>		13b. COUNTY <b>Cooke</b>		13c. CITY OR TOWN <b>S. Holland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>15500 State Street</b>	
14. FATHER'S NAME First <b>John Lawrence</b> Middle <b>Barrett</b> Last			15. MOTHER'S MAIDEN NAME First <b>Grace</b> Middle <b>Dugan</b> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>Yes</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>South Holland</b>		Address <b>Illinois</b> <b>Mrs. Rose Barrett, 15500 State Street,</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MALIGNANT LYMPHOMA WITH MASSIVE INVOLVEMENT OF</b> <b>2022</b> DUE TO, OR AS A CONSEQUENCE OF <b>SMALL BOWEL AND SECONDARY SMALL BOWEL RUPTURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>2002</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>Oct. 17</b> , 19 <b>68</b> , to <b>Oct. 31</b> , 19 <b>68</b> , that <b>(X)</b> (we) lost saw the deceased alive on <b>Oct. 31</b> , 19 <b>68</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(X)</b> (we) did <b>(not)</b> view the body after death.									
22b. SIGNATURE <b>M. D. Gorman</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>Nov. 1, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>M. D. GORMAN, M.D.</b>				22e. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Nov 5, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Lowell Massachusetts</b>			
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b> ADDRESS <b>4739 Baltimore Ave., Hyattsville, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>NOV 6 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

CENTRAL OF TEXAS

1. Name of the person or persons to whom the property is being transferred  
 2. Address of the person or persons to whom the property is being transferred  
 3. Description of the property being transferred  
 4. Date of the transfer  
 5. Signature of the person or persons making the transfer  
 6. Signature of the person or persons receiving the property  
 7. Notary Public for the State of Texas  
 8. Commission Expires

I, \_\_\_\_\_, Notary Public for the State of Texas, do hereby certify that the foregoing is a true and correct copy of the original instrument filed for record in my office on this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_.

9. Notary Public for the State of Texas  
 10. Commission Expires  
 11. Date of the transfer  
 12. Signature of the person or persons making the transfer  
 13. Signature of the person or persons receiving the property  
 14. Notary Public for the State of Texas  
 15. Commission Expires



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
14532					14540					
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>First Middle Last</b> <b>Mabel G. Barton</b>					2a. DATE OF DEATH Month <b>10</b> Day <b>29</b> Year <b>68</b>			2b. HOUR <b>10:05 A.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH <b>5-9-88</b>		6. AGE (In years last birthday) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>NY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.				
10. CITY OR TOWN OF DEATH <b>Slack Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife (Ret.)</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>13002 Camellia DR.</b>		
14. FATHER'S NAME <b>George</b>			15. MOTHER'S MAIDEN NAME <b>Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>			16b. SOCIAL SECURITY NO. <b>143-07-5951</b>		17. INFORMANT <b>DeWitt A Barton, Long Beach, Calif</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA</b> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>443X</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>1966</b> to <b>10/29, 1968</b> , that (I) (we) lost the deceased alive on <b>10/29, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Myron L. Lenkin</b> M.D. DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/29/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>MYRON L. LENKIN, M.D.</b>					22e. ADDRESS <b>2309 Sharf Road Wheaton, Md</b>					
23a. BURIAL (CREMATION REMOVAL) (Specify)		23b. DATE <b>11/1/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Bladenburg Rd. PG. Md</b>				
24. FUNERAL DIRECTOR <b>W. W. Chambers &amp; Son</b>					ADDRESS <b>1400 Chapin St. NW</b>		25a. REC'D BY REGISTRAR <b>NOV 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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OFFICE OF THE

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "OFFICE", "REPORT", and "DATE" are faintly visible.]*



## CERTIFICATE OF DEATH

14533

14541

1. DECEASED-NAME (Type or print) <b>HELEN CUFF BEAN</b>			2a. DATE OF DEATH Month <b>Oct</b> Day <b>22</b> Year <b>1968</b>			2b. HOUR <b>12:10</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Aug. 5, 1888</b>		6. AGE (In years last birthday) <b>80</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Burtonsville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>14824 Old Columbia Pike</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Burtonsville</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>4824 Old Columbia Pike</b>	
14. FATHER'S NAME First <b>John</b> Middle <b>Cuff</b> Last <b>Cuff</b>			15. MOTHER'S MAIDEN NAME First <b>Clara</b> Middle <b>(Unknown)</b> Last <b>(Unknown)</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-54-4625</b>		17. INFORMANT <b>Mrs Hilda A. Shank</b> Address <b>713 Hollywood Ave Silver Spring Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>485X</b> IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>491X</b> (b) <b>Acute Bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 day</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6-8 hrs.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <b>Parkinsons Disease, Advanced Arthritis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (the hospital) attended the deceased from <b>4-23</b> , 19 <b>63</b> , to <b>10-22</b> , 19 <b>68</b> , that (I) (we) saw the deceased alive on <b>10-21</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John R. Spencer, MD.</b>				22c. DATE SIGNED <b>10-22-'68</b>		22d. PHYSICIAN'S NAME (Type) <b>John R. Spencer</b>	
22e. ADDRESS <b>Burtonsville, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/24/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Burtonsville Montg. Md.</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>				25a. DECEASED BY REGISTRAR <b>OCT 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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14551

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OCT 22 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please complete the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR P.
GERTRUDE		M.		BEDELL		Oct. 17, 1968		7:45 M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Female		Cauc.		Dec. 5, 1880		87 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.
Kentucky		U. S.				Montgomery				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda		Grosvenor Nursing Home		Waitress						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
District of Columbia		Washington						6409 33rd St., N. W.		
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last
Unknown								Gertrude M. Masterson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No		405-30-3070A		Daniel B. Bedell		Same as Item 13.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Cardiovascular Collapse										sec. hours
DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary Infarction										sec. hours
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized atherosclerosis										many years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4221 Insufficient due to old age										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (the hospital) attended the deceased from 8/7, 1968, to 10/17, 1968, that (I) (we) last saw the deceased alive on 10/17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)						
George H. Mitchell		10/18/68		GEORGE H. MITCHELL						
				22e. ADDRESS						
				11125 Rockville Pike Rockville, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		10-21-68		Calvary Cemetery		Louisville, Kentucky				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
ROBERT A. PUMPHREY, Bethesda, Maryland				DATE OCT 22 1968		J. Charles Judge				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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14535

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14543

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last John Gordon BELL			2a. DATE OF DEATH OCT Month 30 Day 68 Year		2b. HOUR 0915 M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH 21 August 1946		6. AGE (In years lost birthday) 22 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Tennessee	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital, Bethesda	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE Virginia	13b. COUNTY Fairfax	13c. CITY OR TOWN McLean	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 6909 Lemon Road	
14. FATHER'S NAME First Middle Last Gordon C. BELL	15. MOTHER'S MAIDEN NAME First Middle Last Elinor Powers		Address 6909 Lemon Road		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) 18	16b. SOCIAL SECURITY NO.	17. INFORMANT Capt. Gordon C. Bell, USN, Ret. McLean, Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkins Disease with secondary gastric hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 201X					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (A) (this hospital) attended the deceased from <u>13 October, 1968</u> , to <u>30 October, 1968</u> , that (A) (we) lost saw the deceased alive on <u>30 October</u> 1968, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>D. L. Horton</i>		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 31 OCT 1968		
22d. PHYSICIAN'S NAME (Type) D. L. HORTON, M. D.		22e. ADDRESS NAVAL HOSPITAL, BETHESDA, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-3-68	23c. NAME OF CEMETERY OR CREMATORY Highland Memorial	23d. LOCATION (City or Town) Knoxville	(County) Tenn.	(State)
24. FUNERAL DIRECTOR Robert A. Pumphrey		ADDRESS 7557 Wisconsin Ave. Bethesda, Maryland	25a. REC'D BY REGISTRAR DATE NOV 4 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
14536 CERTIFICATE OF DEATH 14544										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Joseph A. BELL						Month Day Year		October 29 68 1055 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		Caucasian		March 27, 1904		64 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Colorado		USA				Montgomery		Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Naval Hospital			Physician/Epidemiologist		Public Health		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9318 Elmhurst Drive	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Joseph Charles Bell			Bessie Sherman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT					
Yes			1942-46		Road, Rockville Address Md.					
			215 38 97 91		Capt. B. D. LaMar, USN, Ret. 4307 Aspen Hill					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: Myocardial Infarction										
IMMEDIATE CAUSE (a) 4109										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year								
		P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State						
				1050 A.M. 68 1055 A.M.						
22a. I certify that (X) (this hospital) attended the deceased from 29 Oct., 1968, to 29 Oct., 1968, that (X) (we) last saw the deceased alive on 7 August 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS.		22c. DATE SIGNED		
Richard N. Hood M.D.						<input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		29 Oct. 1968		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
Richard N. HOOD, M. D.				Naval Hospital, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		11-2-1968		Parklawn Cemetery		Rockville, Montgomery Co., Md				
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Joseph Gawler Sons				5130 Wisconsin Ave., N.W. Washington, D. C.		DATE NOV 7 1968		J. Charles Judge		

James W. McHugh, Jr., D. D., Mayor, New York, N. Y.

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VR A15 (4)  
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
14537 Item 16a Film 406 10/22/68 14545																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First LOUIS			Middle JOHN			Last BENDER			2a. DATE OF DEATH October Month 8 Day 68 Year			2b. HOUR 1:46 P.M.		
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH 7-23-1892			6. AGE (In years last birthday) 76 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Ohio			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.								
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, or if retired.) Retired Lab. Tech.			12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 2804 Ivydale Street					
14. FATHER'S NAME First Middle Last Rudolph Michael Bender			15. MOTHER'S MAIDEN NAME First Middle Last Louisa -														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) YES 1918-1919			16b. SOCIAL SECURITY NO. 1909-1913			17. INFORMANT Mrs. Betty Clucas, Daughter,			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alveolo-Capillary block + cor pulmonale</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Bronchogenic Carcinoma</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>None</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>9</u> , 19 <u>68</u> , to <u>10/8</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10/7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Edward S. Mehlman</u>			22c. DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 10/9/68								
22d. PHYSICIAN'S NAME (Type) Edward S. Mehlman			22e. ADDRESS 6480 NEW HAMPSHIRE AV TAKOMA PARK, D.C.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10-11-1968			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City or Town) (County) (State) Suitland, Prince Georges, Md.								
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016			25a. REC'D BY REGISTRAR DATE OCT 14 1968			25b. REGISTRAR'S SIGNATURE Charles Judge											





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MARTIN W. HYSONG, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14538									
14546									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
EDITH			H. BENNETT			OCTOBER 21, 1968			2:35 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		WHITE		FEB. 29, 1880		88 YRS.		7 22	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
LONDON, ENGLAND		U.S.A.				MONTGOMERY COUNTY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
KENSINGTON, MD.		CARROLL HALL SANITARIUM		HOUSEWIFE		HOME MAKER			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
DISTRICT OF COL.		WASH. D.C.		WASH. D.C.				5801-UTAH AVENUE, N.W.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
----- HIBBARD			----- HIBBARD						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown))			16b. SOCIAL SECURITY NO.			17. INFORMANT (SON) WASH. D.C. N.W.			
						DR. SYDNEY J. BENNETT 5801 UTAH AVENUE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral TH Embolus</u> <u>4339</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>19 days.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>332x</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>SEP. 19, 1966</u> to <u>21 OCT. 1968</u> , that (I) (we) last saw the deceased alive on <u>21 OCT. 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>C. H. Richwine MD</u>				22c. DATE SIGNED <u>21, 1968</u>					
22d. PHYSICIAN NAME (Type)				22e. ADDRESS					
<u>C. H. RICHWINE, M.D.</u>				<u>3522 WESTERN AVE.</u> <u>CHENY CHASE, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		10/24/1968		GATE OF HEAVEN CEMETERY		WHEATON, MARYLAND			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<u>MARTIN W. HYSONG</u>				<u>Sydney J. Bennett</u>		<u>Charles Judge</u>			
VR A15 30M REV. 1-68				00-1300 N. ST. N.W. WASH. D.C.		OCT 3 3 1968			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14539

CERTIFICATE OF DEATH

14547

1. DECEASED-NAME (Type or print) First Middle Last David Bergart			2a. DATE OF DEATH 10 Month 30 Day 68 Year			2b. HOUR 5:38 M					
3. SEX Male		4. RACE Caus.		5. DATE OF BIRTH MARCH 4, 1880		6. AGE (In years last birthday) 88		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Wheaton			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bookbinder			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE D. C.			13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2101 16th St.				
14. FATHER'S NAME First Middle Last Hennrich			15. MOTHER'S MAIDEN NAME First Middle Last Sana								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 70617 INFORMANT 518-42-1000			Address Ain Berger 3636 16th St. NW					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA vs myocardial infarction minutes 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis chronic DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4500 none											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) locomotive fouled from fall after					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Aug. 1967, to Oct. 1968, that (I) (we) last saw the deceased alive on Oct 17 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE RC Bufalino MD						22c. DATE SIGNED Oct 30, 68					
22d. PHYSICIAN'S NAME (Type) RC. Bufalino, M.D.						22e. ADDRESS 1429 University Blvd W.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE NOV. 1, 1968			23c. NAME OF CEMETERY OR CREMATORY Mount Lebanon Cemetery			23d. LOCATION (City or Town) (County) (State) Hyattsville, Maryland		
24. FUNERAL DIRECTOR Donald M. Stein			ADDRESS 232 Carroll St., N.W. Wash., D.C.			25a. REC'D BY REGISTRAR NOV 4 1968			25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

14540

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14548

1. DECEASED-NAME (Type or print) <b>Stacy LYNN BERRY</b>			2a. DATE OF DEATH Month <b>Oct</b> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>5A</b> M					
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>JAN. 19, 1961</b>		6. AGE (In years last birthday) <b>7</b> YRS.		IF UNDER 1 YEAR MONTHS <b>7</b> DAYS <b>7</b>		IF UNDER 24 HRS. HOURS <b>5</b> MIN. <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Texas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery Co.</b> Md.					
10. CITY OR TOWN OF DEATH <b>Silver Spring, Md.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>child</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>child</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md.</b>			13b. COUNTY <b>montg.</b>		13c. CITY OR TOWN <b>Silver Sp.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2417 East Gate Dr.</b>		
14. FATHER'S NAME First <b>William</b> Middle <b>L.</b> Last <b>Berry</b>			15. MOTHER'S MAIDEN NAME First <b>Carole</b> Middle <b>ANN</b> Last <b>MARX</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT <b>William L. Berry</b> Address <b>2417 East Gate Dr. - Father.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MALIGNANT MESODERMAL TUMOR</b> <b>199.1</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>22 mos.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1992</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work _____ at work _____		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____		State _____	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 1967, to <b>OCT</b> , 1968, that (I) (we) last saw the deceased alive on <b>10/8</b> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>G. Leonard Gold</b> DEGREE _____						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/9/68</b>			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>OCT. 11, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Memorial Garden</b>		23d. LOCATION (City or Town) <b>Falls Church, Virginia</b>		(County) _____		(State) _____	
24. FUNERAL DIRECTOR <b>Donald M. Stein</b>		ADDRESS <b>232 Carroll</b>		25a. REC'D BY REGISTRAR <b>OCT 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					
Hebrew Memorial Funeral Home		St., N.W. Wash., D.C.									

1958

DEPARTMENT OF DEFENSE

401

[Faint, mostly illegible text covering the main body of the document, possibly a memorandum or report.]



1958



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV. 7/68

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR PM	
Baby Girl				Bliss	October 30, 1968		12:10 M	
3. SEX	Female		4. RACE	White		5. DATE OF BIRTH	October 30, 1968	
7a. BIRTHPLACE (State or foreign country)	Maryland		7b. CITIZEN OF WHAT COUNTRY?	USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH	Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Washington San & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md.		13b. COUNTY	Mont.		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME	First Middle Last		James O'Donovan Bliss		15. MOTHER'S MAIDEN NAME	First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)	No		16b. SOCIAL SECURITY NO.			17. INFORMANT	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anencephaly</u> 740 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 750 X <u>Meningo-Encephalitis</u>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>R. Chinn, M.D.</u>		22c. DATE SIGNED 10/30/68		22d. PHYSICIAN'S NAME (Type) R. Chinn, M.D.,				
22e. ADDRESS 1110 Spring St., Silver Spring, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Creation	11-1-68		Washington San & Hospital		Takoma Park, Md.			
24. FUNERAL DIRECTOR	ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J.D. Ruffcorn, 7600 Carroll Ave., Takoma Park, Md.			NOV 4 1968		J. Charles Judge			

14513

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October 3, 1953

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October 3, 1953

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14542		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14550				
1. DECEASED-NAME (Type or print) <b>MARY</b>				First <b>A.</b>	Middle <b>BOBZIEN</b>	2a. DATE OF DEATH October 1, Day 1968		2b. HOUR 1:00 PM		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>June 19, 1893</b>		6. AGE (In years last birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS <b>2</b> DAYS <b>22</b>	IF UNDER 24 HRS. HOURS <b>1</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.				
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>5426 Amberwood Lane</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5426 Amberwood Lane</b>		
14. FATHER'S NAME <b>Charles</b>		First <b>T.</b>	Middle <b>Anson</b>	15. MOTHER'S MAIDEN NAME <b>Elizabeth</b>		First <b>Fagan</b>	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Daughter) <b>Mrs. James H. Doyle, same item # 13</b>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sev. hours</b> <b>sev. weeks</b> <b>many years</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH-BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4200</b> <b>Generalized arteriosclerosis</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 7, 1967</b> to <b>Oct 1, 1968</b> , that (I) (we) lost saw the deceased alive on <b>July 13, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>George H. Mitchell</b>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/11/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>George H. Mitchell, M.D.</b>					22e. ADDRESS <b>11125 Rockville Pike, Rockville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/5/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Hope</b>		23d. LOCATION (City or Town) (County) (State) <b>Tucson, Arizona</b>				
24. FUNERAL DIRECTOR <b>Tyson Wheeler</b>					ADDRESS <b>1331 Rockville Pike, Rock.</b>		25a. REC'D BY REGISTRAR <b>OCT 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

14520

CERTIFICATE OF BIRTH

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14543

14551

1. DECEASED-NAME (Type or print) <b>MARY</b>			First	Middle	Last	2a. DATE OF DEATH Month Day Year <b>OCTOBER 20 1968</b>			2b. HOUR <b>5 10 P M</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>DEC 1, 1883</b>			6. AGE (In years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>HUNGARY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Hungary</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.					
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOLY CROSS HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>			13c. CITY OR TOWN <b>KENNESAW</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5013 DRUID DRIVE</b>	
14. FATHER'S NAME <b>Joseph Ferenc</b>			First	Middle	Last	15. MOTHER'S MAIDEN NAME <b>Unknown</b>			First	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>son</b> <b>Robert Bocsi</b> Address <b>Same as Item 13.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of GI TRACT</b> <b>159X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>159X</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Arteriosclerotic H.D.; Rheumatoid Arthritis</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 1968</b> to <b>Oct 20, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 20, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>H. C. MAGAMZINI</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/20/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>H. C. MAGAMZINI</b>		22e. ADDRESS <b>50 W. Edmonston Dr., Rockville, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-23-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Charles Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Twin Rocks, Penna.</b>			
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland,</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

14551

REMARKS OF DEATH

14551

MARY FEMALE CAUCASIAN 10/1/1883 10/1/1883

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14544

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14552

1. DECEASED-NAME (Type or print) <b>Joseph Anthony Bono, Jr.</b>			2a. DATE OF DEATH Month <b>October</b> Day <b>4</b> Year <b>1968</b>			2b. HOUR <b>9:45</b> AM				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>12 June 1942</b>		6. AGE (In years last birthday) <b>26</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.				
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center, NIH</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Virginia</b>			13b. COUNTY <b>Fairfax</b>		13c. CITY OR TOWN <b>Merrifield</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>2822 Juniper Street</b>	
14. FATHER'S NAME <b>Joseph Anthony Bono, Sr.</b>			15. MOTHER'S MAIDEN NAME <b>Antoinette Picard</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>225-58-9726</b>		17. INFORMANT <b>Bethesda, Maryland 20814</b> <b>The Medical Records, The Clinical Center.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatorenal failure, etiology unknown</b> <b>2050</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute myelocytic leukemia</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b> <b>10 days</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>2043</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <del>XX</del> (this hospital) attended the deceased from <b>26 Sept.</b> , 19 <b>68</b> , to <b>4 Oct.</b> , 19 <b>68</b> , that <del>XX</del> (we) last saw the deceased alive on <b>4 October</b> , 19 <b>68</b> , and that in <del>XX</del> (my) (our) opinion death occurred on the date and hour and from the causes stated above <del>XX</del> (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Brian Goodell M.D.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>4 October 1968</b>				
22d. PHYSICIAN'S NAME (Type) <b>Brian W. Goodell, MD.</b>						22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10-7-68</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Rockbridge Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>RFD 4 Lexington, Virginia</b>				
24. FUNERAL DIRECTOR <b>AMOLE FUNERAL HOME</b>				ADDRESS <b>BUENA VISTA, VA.</b>		25a. REC'D BY REGISTRAR <b>OCT 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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CERTIFICATE OF DEATH

14545

14553

1. DECEASED-NAME (Type or print) <i>VIRGINIA B. H. BOSWELL</i>			2a. DATE OF DEATH Month <i>OCTOBER</i> Day <i>8</i> Year <i>1968</i>			2b. HOUR <i>1:40 PM</i>	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>11/22/89</i>		6. AGE (In years last birthday) <i>78</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>NY</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>MONT GOMERY</i> Md.	
10. CITY OR TOWN OF DEATH <i>SILVER SPRING, MD</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>FORLAND NURSING H/2101 FAIRMONT RD</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>SECRETARY</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>CHAIRMAN association</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. CITY OR TOWN <i>WASH DC</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>2145 Recreation Place</i>	
14. FATHER'S NAME First Middle Last <i>Basil Brooke Hopkins II</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Caroline Ellis</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16b. SOCIAL SECURITY NO. <i>578-42-2450</i>		17. INFORMANT Address <i>Rivington Stane 230 Patuxent Rd Laurel Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Uremia</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>493x</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>months</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Diabetes mellitus - ARTHRITIS RS Spine, General arteriosclerosis</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>8/1</i> , 19 <i>68</i> , to <i>10/8</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10/8</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>R. J. Benack MD</i>				22c. DATE SIGNED <i>10/8/68</i>		22d. PHYSICIAN'S NAME (Type) <i>R. J. Benack MD</i>	
22e. ADDRESS <i>4115 Colie DR. Wheaton, MD.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation 10-9-68</i>		23b. DATE <i>10-9-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cem</i>		23d. LOCATION (City or Town) (County) (State) <i>Calmar Maryland Md</i>	
24. FUNERAL DIRECTOR <i>W. J. Adams D.H.</i>				25a. REC'D BY REGISTRAR <i>W. J. Adams</i>		25b. REGISTRAR'S SIGNATURE <i>W. J. Adams</i>	
DATE <i>OCT 14 1968</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Released By Dr. Reap.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
14546					14554								
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print) <b>JEAN GIBSON BOTELER</b>			First <b>JEAN</b>		Middle <b>GIBSON</b>		Last <b>BOTELER</b>		2a. DATE OF DEATH Month <b>10</b> Day <b>23</b> Year <b>68</b>		2b. HOUR <b>10:30 A</b>		
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>Feb. 27, 1909</b>			6. AGE (In years last birthday) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Pa.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b> Md.				
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Accountant</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Silver Sp.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>522 Margaret Drive</b>			
14. FATHER'S NAME <b>Joseph P. Gibson</b>			First <b>Joseph</b>			Middle <b>P.</b>			Last <b>Gibson</b>			15. MOTHER'S MAIDEN NAME <b>Elva Jennings</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>No</b>			17. INFORMANT <b>Robert Boteler</b>			Address <b>522 Margaret Dr. Silver Spring Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>441.0 Left hemothorax (2500 ml)</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ruptured dissecting thoracic aortic aneurysm.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>451X</b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>1964</b> , to <b>23 Oct</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10 Oct</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Ira N. Tublin</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>10/23/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Ira N. Tublin</b>						22e. ADDRESS <b>800 Pershing Dr., Sil. Spr., Md. 209</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>10-28-1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St. Marks Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Frederick County Md.</b>				
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc. 8434 Ga. Avenue</b>						ADDRESS <b>Sil. Spr. Md.</b>			25a. REC'D BY REGISTRAR <b>OCT 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

14554

1.0 ml (2.00 ml)

thoracic aortic  
anastomosis

1.0 ml (2.00 ml)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14547

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14555

## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Ellenora La France Bowman</i>			2a. DATE OF DEATH Month <i>10</i> Day <i>11</i> Year <i>68</i>			2b. HOUR <i>8:05A</i> M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>2-9-1902</i>		6. AGE (In years last birthday) <i>66</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Kensington</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Kensington Gardens Sanit</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Wheaton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>11832 Huggins Dr</i>	
14. FATHER'S NAME First Middle Last <i>Unknown Morgan</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Unknown</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <i>No</i> (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. <i>YES</i>			17. INFORMANT <i>John E. Bowman</i>			Address <i>Rockville, Md.</i> <i>13212 Twinbrook Parkway</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral vascular catastrophe</i> <i>2509</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetic Mellitus</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> <i>Unknown</i> <i>Unknown</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>260x Pulmonary tuberculosis (Healed)</i>									
19a. DATE OF OPERATION <i>—</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>—</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>2/18</i> , 19 <i>66</i> , to <i>10/11</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>9/16</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>M. S. MADELOFF</i>		22c. DATE SIGNED <i>10/11/68</i>		22d. PHYSICIAN'S NAME (Type) <i>M. S. MADELOFF</i>		22e. ADDRESS <i>10620 GA. AVE. SILVER SPRING MD</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10-15-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Frederick Memorial Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Frederick Maryland</i>			
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>C. Glen Carter</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>OCT 21 1968</i>			

14825

OFFICE OF THE ATTORNEY GENERAL

1911

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are visible.]*

*[Faint text at the bottom of the page, possibly a signature or date.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14548 CERTIFICATE OF DEATH 14556									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
James			Edmund			10 Month 23 Day 68 Year		7. A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
male		Caucasian		12-23-1908		59 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Massachusetts		United States				Montgomery Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		1834 East West Highway		Retired		U.S. Gov't.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Silver Spring				1834 East West Highway	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Frank A. Brady			Grace Cuttle						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
Yes			W.W. 11		272-05-0423 Mrs. Margaret B. Brady, Wife, same as item 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Coronary Occlusion - Probable DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) 4100 Intermittent Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 4201 Hypertensive Vascular Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute 10 years 10+ years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Dysentery, Malaria, Carcinoma of Colon (resected)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from June, 1967, to 10-22, 1968, that (I) (we) last saw the deceased alive on 10-21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Alan M. Weintraub, M.D.					22c. DATE SIGNED 10-23-68		22d. PHYSICIAN'S NAME (Type) Alan M. Weintraub, M.D.		
22e. ADDRESS 5201 Conn. Ave. N.W., Wash., D.C.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10-25-1968		Baltimore National Cem.		Baltimore, Maryland			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., N.W., Wash., D.C., 20016					25a. REC'D BY REGISTRAR DATE OCT 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

1997

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A 104  
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div style="display: flex; justify-content: space-between;"> <span>14549</span> <span>CERTIFICATE OF DEATH</span> <span>14557</span> </div>											
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR			
<div style="display: flex; justify-content: space-between;"> <span>First</span> <span>Middle</span> <span>Last</span> </div> ALBERT W. BRAND						10 Months 21 Day 08 Year		12 30 P M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Male		Wh.		12/21/91		76 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Ohio		USA				Montgomery Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
SilverSpring				HolyCrossHospital				Retired			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.				Montgomery		SilverSp		YES <input type="checkbox"/> NO <input type="checkbox"/>		9731HedinDrivex	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
<div style="display: flex; justify-content: space-between;"> <span>First</span> <span>Middle</span> <span>Last</span> </div> William BRAND						<div style="display: flex; justify-content: space-between;"> <span>First</span> <span>Middle</span> <span>Last</span> </div> - UNK. -					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				577 03 6604		A.W. BRAND		# 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) ArterioscleroticHeartDis;											
4129 DUE TO, OR AS A CONSEQUENCE OF SevereCoronaryArteriosclerosis											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) MyocardialFibrosis; CompleteThrombotic											
DUE TO, OR AS A CONSEQUENCE OF OcclusionOfAnteriorDescending											
(c) BranchOfL CoronaryArtery											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)											
PulmonaryEdema											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 10-6, 1968, to 10-6, 1968, that (I) (we) last saw the deceased alive on 10-6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
J. FREDERICK BARR						DEGREE		10-6-68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
J. FREDERICK BARR						4500 College Ave, College Park, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		10/9/1968		Gate of Heaven		Silver Spring Md					
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm Taltavull						4748 Wisc Ave NW		OCT 9 1968		Charles Judge	

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Montgomery

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USA

Ch. 10

Polycystic Ovarian Disease

Polycystic Ovarian Disease

9781 10/11/53

Montgomery 10/11/53

10/11/53

Arteriosclerotic heart disease;  
Coronary Atherosclerosis;  
Myocardial Infarction; Coronary  
Occlusion of anterior descending  
branch of coronary artery

Myocardial Infarction



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>FLORENCE DOROTHY BRANDT</b>			2a. DATE OF DEATH Oct. Month 27 Day 68 Year			2b. HOUR 7:15 AM			
3. SEX <b>FEMALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH <b>JAN 13, 1886</b>		6. AGE (In years lost birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY COUNTY</b> Md.			
10. CITY OR TOWN OF DEATH <b>SILVER SPRING, MD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>FAIRLAND NURSING HOME</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>WIFE &amp; MOTHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>ROCKVILLE MD</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>604 MCINTYRE RD.</b>	
14. FATHER'S NAME First Middle Last <b>DAVID SOWAAL</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>MORSE</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>102-05-6930-4</b>		17. INFORMANT <b>Mrs. Hazel Deriso</b>		Address <b>Some item # 13E</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2509 Anemia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Stroke &amp; Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>stroke</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>stroke</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>260X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Feb. 22, 1967, to Oct. 1, 1968, that (I) (we) lost saw the deceased alive on 10/24/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Raymond T. Benack</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/27/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Raymond T. Benack</b>				22e. ADDRESS <b>4115 Collie Drive, Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>10/31/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen</b>		23d. LOCATION (City or Town) <b>Brooklyn, New York</b>		(County) (State)	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>				ADDRESS <b>Rockville, Md.</b>		24a. FILED BY REGISTRAR DATE <b>OCT 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1955

DEPARTMENT OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last <i>Emma H. Brayton</i>					2a. DATE OF DEATH Month Day Year <i>Oct. 7 1968</i>		2b. HOUR M. <i>9<sup>45</sup></i>		
3. SEX <i>female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>1/11/22</i>		6. AGE (In years last birthday) <i>46</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Chesapeake</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Store</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Store</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>10104 - Trillium Ave.</i>	
14. FATHER'S NAME First Middle Last <i>John Wright</i>					15. MOTHER'S MAIDEN NAME First Middle Last <i>Myrtle Campbell</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Elbert J. Brayton</i> Address <i>3200 R. Ave.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>1830</i> IMMEDIATE CAUSE (a) <i>Generalized calcinosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cystadenoma, rt. ovary</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>↓</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>1750</i>									
19a. DATE OF OPERATION <i>4/30/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cyst. rt. ovary</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <i>4/30</i> , 19 <i>68</i> , to <i>present</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10/5</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>I. L. Marks, M.D.</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <i>10/8/68</i>				
22d. PHYSICIAN'S NAME (Type) <i>I. L. MARKS, M.D.</i>					22e. ADDRESS <i>320 UNIVERSITY BLVD. E. SUITE 100 SPRING</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10-11-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lone Star Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Covington, Virginia</i>			
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>					25a. REC'D BY REGISTRAR DATE <i>OCT 11 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

14528

1111

CHURCH & BELL

Maria Campbell

John W. W.

Unknown

11



Burial 10-11-01 Fort Scott Cemetery, Cantonment, Virginia

ROBERT A. WATKINS, Baltimore, Maryland, OCT 11 1908

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form **PM-100**. 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. ~~See pages 1 and 2~~ with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14560

VR A15ME (S)  
10M REV. 1/68



14500

MEDICAL EXAMINATION CERTIFICATE OF BIRTH

NAME: [illegible] SEX: [illegible] DATE OF BIRTH: [illegible]

DATE OF EXAMINATION: [illegible] TIME: [illegible]

PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]

DATE OF EXAMINATION: [illegible]

DATE OF EXAMINATION: [illegible]

DATE OF EXAMINATION: [illegible]

DATE OF EXAMINATION: [illegible]

DATE OF EXAMINATION: [illegible]

DATE OF EXAMINATION: [illegible]

DATE OF EXAMINATION: [illegible]

DATE OF EXAMINATION: [illegible]

DATE OF EXAMINATION: [illegible]

DATE OF EXAMINATION: [illegible]

DATE OF EXAMINATION: [illegible]

DATE OF EXAMINATION: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)  
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First <i>Thomas</i>			Middle <i>(NM9)</i>			Last <i>Brennan</i>			2a. DATE OF DEATH Month <i>10</i> Day <i>21</i> Year <i>1968</i>			2b. HOUR <i>9:50 AM</i>		
3. SEX <i>Male</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>Jan. 18, 1901</i>			6. AGE (In years lost birthday) <i>67</i> YRS.			IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) <i>Wash. D. C.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md.								
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wash. San. &amp; Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Carpenter -</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Pr. Geo.</i>			13c. CITY OR TOWN <i>Chillum</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>1307 Ray Road</i>					
14. FATHER'S NAME First <i>John</i> Middle <i>Brennan</i> Last <i>Hunter</i>			15. MOTHER'S MAIDEN NAME First <i>Maria</i> Middle <i>Hunter</i> Last <i>Hunter</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>578-03-6394</i>			17. INFORMANT <i>Evelyn C. Brennan</i> Address <i>1307 Ray Road Chillum, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Emphysema</i> <i>492X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>5271</i>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 11, 1968</i> , to <i>Oct 21, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 21, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Boris Rabkin</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22c. DATE SIGNED <i>Oct 22, 1968</i>					
22d. PHYSICIAN'S NAME (Type) <i>BORIS RABKIN, MD</i>												22e. ADDRESS <i>1019 Univ. Blvd East</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>10-25-1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Prince Georges, Md.</i>								
24. FUNERAL DIRECTOR <i>C. Glen Carter</i> ADDRESS <i>Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S.Md.</i>						25a. REC'D BY REGISTRAR DATE <i>OCT 25 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>								

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REPUBLIC OF CHINA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Edward Thomas Brooke</b>					2a. DATE OF DEATH Month <b>Oct.</b> Day <b>9</b> Year <b>68</b>			2b. HOUR <b>3:30M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>10-10-79</b>		6. AGE (In years last birthday) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Sandy Spring Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Colonial Villa</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Accountant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S.Gov.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. STREET AND NUMBER <b>Sandy Sp.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME First <b>Roger</b> Middle <b>Brooke</b> Last <b>Brooke</b>			15. MOTHER'S MAIDEN NAME First <b>Louisa</b> Middle <b>Thomas</b> Last <b>Brooke</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>unknown</b>		16b. SOCIAL SECURITY NO. <b>579-60-8583</b>		17. INFORMANT <b>Nursing Home Records</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>generalized arteriosclerosis</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4500</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>July, 1964</b> , to <b>10-9, 1968</b> , that (I) <del>was</del> saw the deceased alive on <b>10-8-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.									
22b. SIGNATURE <b>G.F. Sengstack M.D.</b>				DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10-9-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>G.F. Sengstack</b>				22e. ADDRESS <b>Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>Oct. 12, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodside</b>		23d. LOCATION (City or Town) (County) (State) <b>Brinklow, Mont., Md.</b>			
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>				ADDRESS <b>Laytonsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1880



U.S. DEPT. OF AGRICULTURE

Survey

Section 12, Township 12N, Range 10E

Section 12, Township 12N, Range 10E

Section 12, Township 12N, Range 10E

Section 12, Township 12N, Range 10E

Section 12, Township 12N, Range 10E

Section 12, Township 12N, Range 10E

Section 12, Township 12N, Range 10E

Section 12, Township 12N, Range 10E

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)  
30M REV. 1-6-68

14555		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14563	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last Dovie G. Brooks			2a. DATE OF DEATH Month 10 Day 3 Year 1968			2b. HOUR 10:45 P.M.	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 1-5-1894		6. AGE (In years last birthday) 74 YRS.	
7a. BIRTHPLACE (State or foreign country) Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) University Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mortician		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Wash. D.C.		13b. COUNTY D.C.		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 525 21 <sup>st</sup> St. N.E.		14. FATHER'S NAME First Middle Last JAMES PIETERS		15. MOTHER'S MAIDEN NAME First Middle Last JOSEPHINE ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown unknown		16b. SOCIAL SECURITY NO. 579-05-9645		17. INFORMANT LILLIAN SUTTON		Address GARFIELD TERRACE 1125 FLA AVE N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4339 Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Ruptured Arteriosclerosis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 332X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 3/10, 1968, to 10/3, 1968, that (I) (we) last saw the deceased alive on 10/3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Lawrence R. Cannaday, M.D.				DEGREE M.D.		22c. DATE SIGNED 10/3/68	
22d. PHYSICIAN'S NAME (Type) LAWRENCE R. CANNADAY, M.D.				22e. ADDRESS 3632-GEORGIA AVE. N.W. D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10-6-68		23c. NAME OF CEMETERY OR CREMATORY LINCOLN MEM.		23d. LOCATION (City or Town) (County) (State) SUITLAND MD.	
24. FUNERAL DIRECTOR BROOKS & ALLEN				ADDRESS 1200 FLA AVE. N.W.		25a. REC'D BY REGISTRAR OCT 9 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge			





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 406 Maryland State Department of Health  
11-19-68ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
14556 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14564

1. DECEASED-NAME (Type or Print) <b>GEORGE FRANCIS BROWN</b>			2a. DATE KNOWN OF DEATH Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> <b>10 27 1968</b>			2b. HOUR <b>8:45</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>5-20-79</b>	6. AGE (In years last birthday) <b>89</b> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> <b>10 27 1968</b>			2d. HOUR <b>9:05</b>
7a. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>			
10. CITY OR TOWN OF DEATH <b>Silver Spring, Md</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Montgomery General Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>17710 New Hampshire Avenue</b>	
14. FATHER'S NAME First <b>Charles</b> Middle <b>Warner</b> Last <b>Brown</b>			15. MOTHER'S MAIDEN NAME First <b>Sophia</b> Middle <b>C.</b> Last <b>Schneider</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>220-05-3280</b>		17. INFORMANT <b>Elsie J. - Wife</b>		ADDRESS <b>17710 N. H. Ave. S.S., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>10/28/1968</b>									
ACTUAL SIGNATURE <b>Belden R. Reap</b>		EXAMINER'S NAME (Type) <b>BELDEN R. REAP MD.</b>		ADDRESS <b>Prince Georges, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-31-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Burtonsville Union Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges, Md.</b>			
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>		C. Glen Carter <b>8434 Ga. Ave. S.S., Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1950

MEDICAL TREATMENT CERTIFICATE OF DISABILITY

UNITED STATES DEPARTMENT OF THE ARMY

DATE: 10-27-50

TO: 10-27-50

FROM: 10-27-50

SUBJECT: 10-27-50

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## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>CHARLES BOWLES BRUCE</b>			2a. DATE OF DEATH Month <b>Oct</b> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>5:28</b> M	
3. SEX <b>MALE</b>		4. RACE <b>Colored</b>		5. DATE OF BIRTH <b>8-10-12</b>		6. AGE (In years last birthday) <b>56</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Kent's Store VA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Federal Gov't D.C.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PAUL KANT</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>210 Frederick Ave -</b>		14. FATHER'S NAME First <b>Richard</b> Middle <b>Bruce</b> Last <b>Bruce</b>		15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>FRANKLIN</b> Last <b>FRANKLIN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Irene Mary Bruce</b>		Address <b>Rockville 210 Frederick Ave</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1960</b> to <b>Sept 9, 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept 20, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>D.L. Bruce / SN Jones</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10-9-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>D.L. Bruce / SN Jones</b>		22e. ADDRESS <b>809 Veirs Mill Rd Rockville</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>10-11-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Kent's Store Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>KENT, S STORE, VA</b>	
24. FUNERAL DIRECTOR <b>ROBERT L. SNOWDEN</b>		ADDRESS <b>ROCKVILLE, MD</b>		25a. REC'D BY REGISTRAR <b>OCT 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

14558												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												14566			
1. DECEASED-NAME (Type or print) First Middle Last AMELIA F. BRUSH												2a. DATE OF DEATH Month Day Year 10 30 68												2b. HOUR 10 30 P M			
3. SEX F.				4. RACE W.				5. DATE OF BIRTH 5-16-09				6. AGE (In years last birthday) 59 YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN							
7a. BIRTHPLACE (State or foreign country) ITALY				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH MONT. Md.															
10. CITY OR TOWN OF DEATH SILVER SPRING				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS HOSP				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Own home															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY MONT.				13c. CITY OR TOWN SILVER SPRING				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 1713 GRIDLEY LANE											
14. FATHER'S NAME First Middle Last Frank Ferrara				15. MOTHER'S MAIDEN NAME First Middle Last Pauline Petoia																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No				(If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 578-07-6011				17. INFORMANT David Brush				Address 1713 Gridley Lane, Sil. Spr. Md											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 260x Diabetes mellitus.																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from March, 1968, to 30 Oct, 1968, that (I) (we) lost saw the deceased alive on 30 Oct 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE Ira Dublin MD				DEGREE MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 10/31/68															
22d. PHYSICIAN'S NAME (Type) Ira Dublin MD				22e. ADDRESS 800 Pershing Drive, Sil. Spr. Maryland																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 11-4-1968				23c. NAME OF CEMETERY OR CREMATORY Gates of Heaven				23d. LOCATION (City or Town) (County) (State) Silver Spring Montg. Md.															
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave.				ADDRESS Sil. Spr. Md				25a. REC'D BY REGISTRAR DATE NOV 7 1968				25b. REGISTRAR'S SIGNATURE J Charles Judge															

14200

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY



7

1908

NOV 1 1908



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) <b>LILAH ANN BUCKLER</b>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>10</b> Day <b>19</b> Year <b>1968</b>		2b. HOUR <b>M</b>
3. SEX <b>Fe</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH <b>7-3-1968</b>	6. AGE (In years last birthday) <b>3</b> YRS. <b>16</b> MONTHS <b>3</b> DAYS <b>16</b>	7c. DATE PRONOUNCED DEAD <b>10 19 1968</b>
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Montgomery</b>	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. San &amp; Hosp</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Montg.</b>	13c. CITY OR TOWN <b>TAK. PK</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME First <b>Francis D</b> Middle <b>Buckler</b> Last <b>Buckler</b>		15. MOTHER'S MAIDEN NAME First <b>Patricia</b> Middle <b>Unglaub</b> Last <b>Unglaub</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>HOSP. RECORDS</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>10/19/68 Intracranial Hemorrhage</b> <b>913.0</b> DUE TO, OR AS A CONSEQUENCE OF Subdural and subarachnoid hemorrhage due to Intracranial hemorrhage, cause undetermined				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10/19/68</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>924.0</b>				
19a. DATE OF OPERATION <b>10-10-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>10-10 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Infant caught head between crib frame and mattress</b>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>		21f. LOCATION Street or R.F.D. No. <b>Takoma Park</b> City or Town <b>Montg.</b> County <b>Md.</b> State
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Belden R. Reap</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>10/19/1968</b>
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-22-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Asburg Methodist Ch. Arnold Md.</b>
24. FUNERAL DIRECTOR <b>W.W. Chambers C</b>		ADDRESS <b>Silver Spring Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 23 1968</b>
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

14557

OFFICE EXAMINER, DEPARTMENT OF HEALTH

TOP STATE

1914

X 10-19-14

LILA Ann BUCKLER

Case T-3-1914

10-2-14

X

10-19-14

10-19-14

X

10-19-14

10-19-14

10-19-14

X

X X X

10/14/14

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10/14/14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then place page 3 in the envelope with pages 1 and 2 and place the envelope in the casket. The envelope should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
14560					14568					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH		2b. HOUR			
ALEXANDER					OCT 3 1968		10 A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE		WHITE		9-15-1875		93 YRS		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
RUSSIA		U S A				MONTGOMERY Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring			FAIRLAND NURSING HOME							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
316 BEAUMONT RD			MONTGOMERY		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
BTZALAIOL			NEHA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes, no, or (unknown)			579-16-7940		Morris Burak (son)		5002 3rd St., N.W. Wash., D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Congestive Heart Failure										
DUE TO, OR AS A CONSEQUENCE OF										
(b) Myocarditis										
DUE TO, OR AS A CONSEQUENCE OF										
(c) Influenza										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Arteriosclerotic Heart Disease, Bronchitis, Generalized arteriosclerosis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 10/2, 1968, to 10/3, 1968, that (I) (we) lost the deceased alive on 10/3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
R.T. Benack								10/3/68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
R.T. Benack MD		4115 Colie Rd. Wheaton								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		OCT. 4, 1968		Beth Shalom Cemetery		Hillside, Maryland				
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Donald M. Stein		232 Carroll		J. Charles Judge						
Hebrew Memorial Funeral Home		St., N.W. Wash., D.C.		OCT 7 1968						

14508

UNITED STATES

1950

CHARGE

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1950-18

1950-18

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR
Lucy Benson Burdette								Month Day Year		2b. HOUR
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7c. DATE PRONOUNCED DEAD		7d. HOUR
Fe -		W -		Nov 23, 1888		79 YRS.		Month Day Year		7d. HOUR
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH -		MD.
Maryland		U.S.A.		WIDOWED		DIVORCED		Montgomery		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Gaithersburg		Asbury Methodist Home		Housewife						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.		Montgomery		Hyattstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last
James Benson								Mary Jane Allnut		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
		215-647402		Asbury Methodist Home		Fairfax Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u>										5 days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>										years -
DUE TO, OR AS A CONSEQUENCE OF (c) <u>General Arteriosclerosis</u>										years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4200										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				2D. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		John B. Ball		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Oct 7, 1968		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
						ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		10-9-68		Hyattstown M. & Ch.		Hyattstown Montg Md				
24. FUNERAL DIRECTOR		Ernest O. Gartner		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Ernest O. Gartner						DATE OCT 10 1968		Charles Judge		

14523

STANDARD EXAMINATION OF WATER



OCT 10 1988



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Cleared with Dr. Ball, county medical examiner*

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14562

14570

1. DECEASED-NAME (Type or print) <b>Merle</b>			First Middle Lost <b>McComas</b>			Last <b>Burdette</b>			2a. DATE OF DEATH Month <b>1</b> Day <b>1968</b> Year			2b. HOUR <b>5:45</b> PM		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>7/25/12</b>			6. AGE (In years lost birthday) <b>56</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b>			Md.		
10. CITY OR TOWN OF DEATH <b>Olney</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Montgomery General</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Painter</b>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Montg.</b>			13c. CITY OR TOWN <b>Damascus</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>27400 Ridge Rd.</b>		
14. FATHER'S NAME <b>Moody</b>			First Middle Lost <b>McComas</b>			Last <b>Burdette</b>			15. MOTHER'S MAIDEN NAME <b>Ellen</b>			First Middle Lost <b>G. Kidwell</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO. <b>215-01-2828</b>			17. INFORMANT <b>Mrs Hazel Burdette, Damascus, Md.</b>			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>A.S.C.V.D.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b> <b>1 wk</b> <b>2 YEARS</b>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (the hospital) attended the deceased from <b>8/30</b> , 19 <b>68</b> , to <b>10/1</b> , 19 <b>68</b> , that (I) (the hospital) saw the deceased alive on <b>9/30</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.														
22b. SIGNATURE <b>James P. Kerr M.D.</b>						DEGREE <b>M.D.</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>10/2/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>James P. Kerr, M.D.</b>						22e. ADDRESS <b>Damascus, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Oct. 4, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon</b>			23d. LOCATION (City or Town) (County) (State) <b>Nr. Damascus, Md.</b>					
24. FUNERAL DIRECTOR <b>Olin L. Molesworth, Damascus, Md.</b>						ADDRESS			25a. REC'D BY REGISTRAR <b>OCT 3 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

19270

THE CASE OF DEATH

19270



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

14563

14571

1. DECEASED-NAME (Type or print) <span style="float: right;">First Middle Last</span> <b>BRUCE EARL BURKHOLDER</b>			2a. DATE OF DEATH Month <u>10</u> Day <u>17</u> Year <u>68</u>		2b. HOUR <u>4:30</u> PM
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>6/25/16</b>	
6. AGE (In years lost birthday) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u>		IF UNDER 24 HRS. HOURS <u>  </u> MIN. <u>  </u>	
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.					
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASHINGTON SAN. &amp; Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>lab tech</b>	
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>	
13c. CITY OR TOWN <b>TAKOMA PARK</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6619 Poplar Ave.</b>	
14. FATHER'S NAME First Middle Last <b>SIMON BURKHOLDER</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>MARGARET OHIER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>		16b. SOCIAL SECURITY NO. <b>191 094796</b>		17. INFORMANT Address <b>HOSPITAL RECORDS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Lung with spinal and meta stases</b> <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 mo.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>163X</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>  </u> <u>  </u> <u>  </u> <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>68</u> , to <u>Oct 17</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Oct 17</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i> DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>Oct 18 68</u>	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/21/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Grove Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>MT Morris Pa.</b>		24. FUNERAL DIRECTOR <b>Valleys Funeral Home</b> <b>MT Rainier Maryland</b>			
25a. DIED BY REGISTRAR DATE <b>OCT 21 1968</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

17221

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

14566

14572

1. DECEASED-NAME (Type or print) <b>NORMA P. BURNS</b>		First <b>NORMA</b> Middle <b>P.</b> Last <b>BURNS</b>		2a. DATE OF DEATH Month <b>10</b> Day <b>15</b> Year <b>1968</b>		2b. HOUR <b>3:30</b> P.M.	
3. SEX <b>F</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>8-24-1895</b>		6. AGE (In years lost birthday) <b>73</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>ILLINOIS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hosp</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>RET.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>3557 LEISURE WORLD BLVD.</b>		14. FATHER'S NAME First <b>HERMAN</b> Middle <b>C.</b> Last <b>KLIPPEL</b>		15. MOTHER'S MAIDEN NAME First <b>NELLIE</b> Middle <b>BUCKLEY</b> Last <b>BUCKLEY</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>579-42-1258B</b>		17. INFORMANT Address <b>LEONARD D. BURNS, HUSBAND, SAME AS ITEM 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4109</b> <b>Acute left posterolateral myocardial infarct</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>YRS.</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b> <b>Diabetes Mellitus</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 30, 1968</b> , to <b>OCT. 15, 1968</b> , that (I) (we) last saw the deceased alive on <b>OCT. 14, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Albert H. Grollman</b> DEGREE <b>ATTENDING PHYS.</b> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>10/16/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>ALBERT H. GROLLMAN</b>				22e. ADDRESS <b>1106 SPRING ST. SILVER SPRING</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>10-18-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR, ADDRESS <b>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</b>				25a. REC'D BY REGISTRAR <b>OCT 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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## CERTIFICATE OF DEATH

14573

14565

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the coroner's pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) <b>ROBERTA</b>			First Middle Last			2a. DATE OF DEATH Month Day Year <b>OCT 14 1968</b>			2b. HOUR <b>1:10 P.M.</b>		
3. SEX <b>FEMALE</b>			4. RACE <b>NEGRO</b>			5. DATE OF BIRTH <b>1/27/97</b>			6. AGE (In years lost birthday) <b>71</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.		
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SUBURBAN</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Maid</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>			13c. CITY OR TOWN <b>D.C.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>4408 Gault Pl. N.E.</b>			14. FATHER'S NAME <b>George Myrick</b>			15. MOTHER'S MAIDEN NAME <b>Rosa Brown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Dora Bush</b>			Address <b>726-50 14th St Phila Pa</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gram negative Sepsis</b> <b>2509</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>multiple decubiti</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>1 mo.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>260x</b> <b>decubiti mellitus</b> <b>Chromosomal disorders</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Myron L. Lerner</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>10/14/68</b>		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>10-14-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln</b>			23d. LOCATION (City or Town) (County) (State) <b>Southland Rd Md.</b>		
24. FUNERAL DIRECTOR <b>AS Washington &amp; Sons</b>						ADDRESS <b>4925 Deane Ave NE.</b>			25a. REC'D BY REGISTRAR <b>PCT 17 1968</b>		
									25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14566

CERTIFICATE OF DEATH

14574

1. DECEASED-NAME (Type or print) <i>Lawrence A. Cady</i>			2a. DATE OF DEATH Month <i>Oct.</i> Day <i>31</i> Year <i>1968</i>			2b. HOUR <i>4:30</i> M	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>May 30 1902</i>		6. AGE (In years last birthday) <i>66</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Retired and Disabled Employees</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>retired</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Mont. George Chase</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4114 - Stanford St.</i>	
14. FATHER'S NAME First <i>Michael J.</i> Middle <i>Cady</i> Last <i>Cady</i>			15. MOTHER'S MAIDEN NAME First <i>Julia</i> Middle <i>Costello</i> Last <i>Costello</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <i>yes U.S. 1945-1946</i>			16b. SOCIAL SECURITY NO. <i>4201</i>		17. INFORMANT Name <i>Marian C. Johnson</i> Address <i>5900 K St. N.W. Washington, D.C.</i>		
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>10/19/68</i> , 19 <i>19</i> , to <i>10/31/68</i> , 19 <i>19</i> , that (I) <i>yes</i> last saw the deceased alive on <i>10/31/68</i> , 19 <i>19</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>yes</i> (did) <i>not</i> view the body after death.							
22b. SIGNATURE <i>Timothy James Tehan</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>10/31/68</i>	
22d. PHYSICIAN'S NAME (Type) <b>TIMOTHY JAMES TEHAN, MD.</b>				22e. ADDRESS <b>8218 Wisconsin Ave, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/4/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 6 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1952

1952

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MB.

D.D.

1952

14567

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Herbert Leslie CAMPBELL</b>			2a. DATE OF DEATH Month <b>October</b> Day <b>13</b> Year <b>1968</b>			2b. HOUR <b>3:25AM</b>			
3. SEX <b>Male</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH <b>8 April 1923</b>		6. AGE (In years last birthday) <b>45</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Colorado</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Foreign Service Officer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>State Dept</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Virginia</b>		13b. COUNTY <b>Fairfax</b>		13c. CITY OR TOWN <b>Greenway</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Madeira School</b>	
14. FATHER'S NAME First Middle Last <b>Elmer L. CAMPBELL</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Stella KRAMER</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>12-14-42-1-4-46 522220529</b>		17. INFORMANT <b>Madeira School, Mary K. CAMPBELL Greenway, Virginia</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized lymphosarcoma</b> <b>2001</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>2001</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <b>(X)</b> (this hospital) attended the deceased from <b>4 Oct 1968</b> , 19____, to <b>13 Oct 1968</b> , that <b>(X)</b> (we) last saw the deceased alive on <b>13 Oct 1968</b> , 19____, and that in <b>(X)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (we) (did) <b>(not)</b> view the body after death.									
22b. SIGNATURE <b>J. E. Zimmerman M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>Oct. 14, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>J. E. ZIMMERMAN, M.D.</b>				22e. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>15 Oct 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Prince Geo, Md.</b>			
24. FUNERAL DIRECTOR <b>DM Eickenberger</b>				ADDRESS <b>Money and King Funeral Home, Vienna, Va.</b>		25a. REC'D BY REGISTRAR <b>OCT 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

REPORT MADE BY: [illegible] DATE: [illegible]

DATE OF DEATH: [illegible] PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DEATH CERTIFICATE NO. [illegible]

REGISTRATION NO. [illegible]

DATE OF REGISTRATION: [illegible]

REGISTRATION OFFICE: [illegible]

REGISTRATION DISTRICT: [illegible]

REGISTRATION OFFICER: [illegible]

REGISTRATION ASSISTANT: [illegible]

REGISTRATION CLERK: [illegible]

REGISTRATION CHIEF: [illegible]

REGISTRATION SUPERVISOR: [illegible]

REGISTRATION MANAGER: [illegible]

REGISTRATION DIRECTOR: [illegible]

REGISTRATION COMMISSIONER: [illegible]

REGISTRATION SECRETARY: [illegible]

REGISTRATION ASSISTANT SECRETARY: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14568					14576				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
AUBREY SYLVESTER CARROLL						October 29 1968			5:35 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE		WHITE		9-12-08		60 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
MD.		U.S.				MONTGOMERY County Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
TAKOMA PARK			WASH. SAN E HOSPITAL			DISABLED			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN (If inside city limits? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> )		13e. STREET AND NUMBER		
MD			PR GEO		WASH., D.C.		6320 SUITLAND RD. 20023		
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Lost
J. Geo. T. CARROLL						ANN S. PAGGETT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No			579-10-0418			GRACE C. ARMSTRONG-6320-SUITLAND RD SE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1621 Pulmonary infarction								Minutes	
Pulmonary embolism								Minutes	
Bronchogenic carcinoma								Months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus; Obesity; 2° pneumonia									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
10/22/68						YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from SEPT, 1968, to PRESENT, that (I) (we) lost saw the deceased alive on 10/29 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
Kenneth Cruze						Oct. 30-68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
Kenneth Cruze						831-University Blvd E. Silver Spring Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			Nov. 1-1968		Christ Church Cem.		Clinton Md		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Simmons' Brothers-1444-Good Hope Rd SE						DATE NOV 1 1968		J. Charles Judge	

14218

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 6 FILMG408 11/1/68 EP  
CERTIFICATE OF DEATH

14577

1. DECEASED-NAME (Type or print) <b>Marion Holly Carter</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>16</b> Year <b>68</b>			2b. HOUR <b>4:20 A.M.</b>				
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>4-14-09</b>		6. AGE (In years last birthday) <b>59 5/8</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>ALA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Amer.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.				
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. San. + Hosp. Clerk</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laundry</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md.</b>			13b. COUNTY <b>P. 9.</b>		13c. CITY OR TOWN <b>Lanham</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5606 Whitfield Chapel Rd</b>	
14. FATHER'S NAME First <b>Frank</b> Middle <b>Carter</b> Last <b>Rogers</b>			15. MOTHER'S MAIDEN NAME First <b>Mabel</b> Middle <b>Rogers</b> Last <b>Rogers</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service) <b>None</b>			16b. SOCIAL SECURITY NO. <b>253-05-0019</b>		17. INFORMANT <b>Patient's chart</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4129</b> IMMEDIATE CAUSE (a) <b>Probable cardiac arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Severe Coronary atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 to 10 minutes</b> <b>15 years</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201 Lobular pneumonia of lower lobe of left lung</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 1967, to <b>OCT 15</b> , 1968, that (I) (we) last saw the deceased alive on <b>OCT 15</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Robert B. Irey</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10-16-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>ROBERT B. IREY</b>						22e. ADDRESS <b>11161 New Hampshire Ave., Silver Spring, Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>OCT. 19, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Athens City Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Athens Limestone, Ala.</b>		
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>			ADDRESS <b>Hyattsville, Md</b>			25a. REC'D BY REGISTRAR <b>OCT 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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Male

Montgomery

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ALA.

Landau

Wash. State Hosp. Creek

Takoma Park

Star White Chapel

Louisa

W. G.

Mr.

Rodgers

Model

Carter

Frank

323-02-01 Patient's chart

Mr. Bone

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Carter  
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4-11-01  
white  
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Montgomery  
amer  
ALA.  
Landau  
Wash. State Hosp. Creek  
Takoma Park  
Star White Chapel  
Louisa  
W. G.  
Mr.  
Rodgers  
Model  
Carter  
Frank  
323-02-01 Patient's chart  
Mr. Bone

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## Items 18-22a Film 406 Maryland State Department of Health DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14578

1. DECEASED NAME (Type or Print) <b>ALICE TRIST CASAP M. Cassap</b>		First Middle Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 10-31 1968		2b. HOUR 11:55	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>1-28-96</b>	6. AGE (In years last birthday) <b>72 YRS.</b>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 10 Day 31 Year 1968	
7a. BIRTHPLACE (State or foreign country) <b>Mich.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. San. &amp; Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>S.S.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <b>John Mattigan</b>		First Middle Last		15. MOTHER'S MAIDEN NAME <b>Mary Duggan</b>		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>579-48-3051M</b>		17. INFORMANT <b>Daughter</b>		ADDRESS <b>Mrs. Judith McCombs, 13811 Eastland St., Rockville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation due to smoke</b> <b>890X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>inhalation and multiple burns, generalized</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>9160</b>							
19a. DATE OF OPERATION <b>11-4-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Deceased burned in housefire</b>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>11-4-68 10-31 P.M.</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Deceased burned in housefire</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>Silver Spring Montg. Md.</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D. EXAMINER'S NAME (Type) <b>Belden R. Reap, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <b>Nov. 1, 1968</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/4/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring Mont. Md.</b>	
24. FUNERAL DIRECTOR <b>M. Andrew Duwall Warner E. Pumphrey Inc. 8434 Ga. Ave. S.S., Md.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



14518

MEDICAL EXAMINER CENTRAL DEPT. OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>First LOUISE Middle R. Last CATTANEO</b>						2a. DATE OF DEATH <b>October 15 1968</b>			2b. HOUR <b>9 AM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Nov 5, 1985</b>		6. AGE (in years last birthday) <b>83</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Venice, Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery County Md.</b>					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Chesapeake Nrsng. Home</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>1604 Lamar Road, Wash. D.C.</b>				13b. CITY OR TOWN <b>Wash. D.C.</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <b>Bethesda, Maryland</b>			
14. FATHER'S NAME <b>First JOHN Middle Last DECAL</b>				15. MOTHER'S MAIDEN NAME <b>First - Middle Last</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b>				16b. SOCIAL SECURITY NO. <b>77-01-8193-D</b>		17. INFORMANT <b>- MR PETER CATTANEO, SON</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>485X Branchiopneumonia</b>											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<b>arteriosclerotic heart disease with chronic failure</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>8 1966</b> , 19 <b>10-15-68</b> , that (I) (we) lost saw the deceased alive on <b>10-15-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>@ P Ryland</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10-15-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>@ P RYLAND</b>						22e. ADDRESS <b>4400-49th St. Washington, D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-18-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</b>						25a. REC'D BY REGISTRAR <b>OCT 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

12818

DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF ENGINEERS  
WASHINGTON, D. C.

REPORT OF THE  
COMMISSIONER OF THE  
GENERAL LAND OFFICE

12818

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "land" and "survey" are faintly visible.]*

... 12-18-1900 ...  
To the ...  
... 12818 ...

FOR STATE  
HEALTH DEPT.

Item#2a&8, Film#406 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) <b>14572 Elias</b>		First Middle Last <b>nmn Chintolas</b>		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 10- 21 19 68		2b. HOUR M	
3. SEX <b>Male</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>1-15-1880</b>	6. AGE (In years last birthday) <b>88</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year <b>10 21 68</b>	
7a. BIRTHPLACE (State or foreign country) <b>GREECE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Takoma Park, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington San. &amp; Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>RESTAURANTEUR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>RESTAURANT</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
13e. STREET AND NUMBER <b>900 Mc CENEY AVE.</b>		14. FATHER'S NAME First Middle Last <b>GEORGE CHINTOLAS</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>HELEN UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>563-16-4443</b>		17. INFORMANT <b>DEMERIOS TSINTOLAS</b>		ADDRESS <b>900 Mc CENEY AVE. SILVER SPRING MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute barbiturate intoxication due to</b> <b>9500</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>overdose of Nembutal</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>9702</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. - P.M. <b>10-21 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Deceased, depressed, took overdose of nembutal</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>Silver Spring Montg Md.</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Belden R. Keap</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>10/21/68</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. KEAP M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town or county) <b>Washington Judge</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>23 Oct. 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GLENWOOD CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON MONTG MARYLAND</b>	
24. FUNERAL DIRECTOR <b>PINAZI FUNERAL HOME</b>		ADDRESS <b>7400 GEORGIA AVE. NW DC</b>		25a. REC'D BY REGISTRAR <b>OCT 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in the space provided. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, holding with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14280

WESTERN EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

10-27-00

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14581

1. DECEASED-NAME (Type or Print) <b>Inez</b>			First Middle Last <b>L. Clark</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> Month <b>10</b> -Day <b>19</b> Year <b>1968</b>			2b. HOUR <b>11:40</b>			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>6-30-91</b>		6. AGE (In years less birthday) <b>77</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>Demarest, Georgia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b>			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington San &amp; Hosp</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired clerk-U.S. Coast Guard</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Takoma Park</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>7241 Garland Ave.</b>		
14. FATHER'S NAME <b>Felix William Walker</b>			First Middle Last <b>House</b>			15. MOTHER'S MAIDEN NAME <b>Lula Nellwell</b>			First Middle Last <b>Dillard</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Lucille Gotthardt</b>			ADDRESS <b>7241 Garland Ave</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 Acute Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>last.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		County	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Belden R. Reed</b>			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>10/19/68</b>			
EXAMINER'S NAME (Type) <b>BELDEN R. REED</b>			ADDRESS <b>2901 14th St. N.W.</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS <b>Washington, D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>			23b. DATE <b>10/22/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Ft. Myer, Va.</b>				
24. FUNERAL DIRECTOR <b>The S.H. Hines Company</b>						ADDRESS <b>2901 14th St. N.W.</b>			25a. REC'D BY REGISTRAR <b>10/23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>William J. Jones</b>	



14581

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

PLANT INDUSTRY REPORT

FOR THE  
YEAR 1911

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(11)

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(15)

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(19)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14574

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14582

1. DECEASED-NAME (Type or print) <b>Julius Renaldo CLARK</b>			2a. DATE OF DEATH <b>Oct.</b> Month <b>15</b> Day Year <b>68</b>			2b. HOUR <b>1040 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>Apr. 10, 1967</b>		6. AGE (In years last birthday) <b>1</b> YRS. <b>10</b> MONTHS <b>10</b> DAYS		IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>N/A</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>St. Mary's</b>		13c. CITY OR TOWN <b>Park Lexington</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>72 Coral Place</b>	
14. FATHER'S NAME First Middle Last <b>Thomas Lee Clark</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Frances Johnson</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT Address <b>Park, Md.</b> <b>Mrs. Mary F. Clark, 72 Coral Pl. Lexington</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Hemorrhagic Bronchial Pneumonia</b> <b>485X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>491X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>3:00 P.M.</b>					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State <b>3:00 P.M.</b>					
22a. I certify that <b>(A)</b> (this hospital) attended the deceased from <b>Oct. 15 / 19 68</b> , to <b>Oct. 15, 19 68</b> , that (I) (we) last saw the deceased alive on <b>Oct. 15 1968</b> , and that in <b>(our)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(I)</b> (we) (did) (do not) view the body after death.									
22b. SIGNATURE <b>Bernard Jay Bortz</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>Oct. 16, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Bernard Jay Bortz, M. D.</b>				22e. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 18, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>First Baptist Church Cemetery, Hermansville</b>		23d. LOCATION (City or Town) (County) (State) <b>Md.</b>			
24. FUNERAL DIRECTOR <b>Leonardtont, Maryland</b>				25a. REC'D BY REGISTRAR <b>OCT 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

2004/05.

*SM* *phosphorylation* *inhibits* *transcription*

D. N. Sifton, Ph.D., University of Illinois at Chicago

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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

24.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14575					14583				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last		2a. DATE OF DEATH			2b. HOUR	
MARGARET			CLASPY		10-20-68			12:15	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		8. YRS.	
Female		Caucasian		3-1-1880		88			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Washington, D.C.		United States				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give full address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER	
Maryland		Montgomery		Silver Spring				1702 Alberti Drive	
14. FATHER'S NAME			First Middle Last		15. MOTHER'S MAIDEN NAME			First Middle Last	
John			Riddle		-				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			-		Silver Spring, Md. William G. Claspy Jr., Son, 1702 Alberti Drive				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE								30 Minutes	
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
ARTERIOSCLEROTIC HEART DISEASE WITH HYPERTENSION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 8-6-1949, to 10-7-1968, that (I) (we) last saw the deceased alive on 10-7-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
C.P. Ryland				10-20-68					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS		22f. ADDRESS			
C.P. RYLAND				4400-49 St. N.W.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) County, Md.			
Burial		10-23-1968		Fort Lincoln Cemetery		Bladensburg, Prince Georges			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons, Inc., N.W., Wash., D.C., 20016				5130 Wisc. Ave. DATE OCT 23 1968		J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14576

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14584

1. DECEASED-NAME (Type or print) <i>Betty</i> First Middle Last <i>Cole</i>			2a. DATE OF DEATH Month <i>Oct.</i> Day <i>27</i> Year <i>68</i>			2b. HOUR <i>4:15</i> M	
3. SEX <i>F</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>8/29/24</i>		6. AGE (In years last birthday) <i>44</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>England</i>		7b. CITIZEN OF WHAT COUNTRY? <i>British</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Specialist</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Farmington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <i>F. Suggden</i> First Middle Last		15. MOTHER'S MAIDEN NAME <i>Winifred Taylor</i> First Middle Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>None</i> (If yes give war or dates of service) ***		16b. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mr. James Cole</i>		Address <i>Same as above</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1830 Inflammation</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Abdo Carcinomatosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of ovary</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 mo.</i> <i>4 mos</i> <i>18 mos</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>1750</i>							
19a. DATE OF OPERATION <i>June 68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intestinal Obstruction</i>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>April</i> , 19 <i>68</i> , to <i>date</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10-27</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>		DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>10-27-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>DR A.F. CASTRO</i>		22e. ADDRESS <i>11125 Rockville Pk. Rockville Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE <i>10/29/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Pr. Geo. Md.</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY</i>		ADDRESS <i>Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>NOV 4 1968</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14577 Liberata											
14585											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>Liberata</b>				First <b>LIBERATA</b> Middle <b>COLELLA</b> Last <b>COLELLA</b>				2a. DATE OF DEATH Month <b>October</b> Day <b>27</b> Year <b>1968</b>		2b. HOUR <b>3:30 P M</b>	
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>Feb 16-1885</b>		6. AGE (In years last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>ITALY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.					
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) <b>RANDOLPH HILLS N.H.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>BETHESDA</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>9303 WISCONSIN AVENUE</b>			
14. FATHER'S NAME First <b>DOMENICO</b> Middle <b>PATRIZIO</b> Last <b>—</b>				15. MOTHER'S MAIDEN NAME First <b>—</b> Middle <b>—</b> Last <b>—</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT Address <b>MR. DOMINIC COLELLA, SON, SAME AS ITEM #13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral thrombotic strokes</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension, cerebral arteriosclerosis &amp; cardiac ischemia</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 years</b> <b>20 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>44.3 x old age.</b>											
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>—</b> , 19 <b>48</b> , to <b>Oct 27, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 27, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>R.N. Manganaro, M.D.</b> DEGREE <b>—</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>10/27/68</b>							
22d. PHYSICIAN'S NAME (Type) <b>R. N. Manganaro, M.D.</b>				22e. ADDRESS <b>1410-MASS. AVE. N.W.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-31-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Mont. Co., Md.</b>					
24. FUNERAL DIRECTOR <b>Joseph Gulerisious</b> ADDRESS <b>5730 Wisconsin Ave NW</b>				25a. REC'D BY REGISTRAR <b>OCT 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>					

14588

839 08 700

**FOR STATE  
HEALTH DEPT.**

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14586

1. DECEASED-NAME (Type or Print) <i>Ralph Adolph Colwell</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> <i>Oct. 27 19 68</i>			2b. HOUR <i>8:30</i>			
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Nov. 4 1915</i>	6. AGE (In years last birthday) <i>52</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month <i>Oct.</i> Day <i>27</i> Year <i>19 68</i>	2d. HOUR <i>8:30</i>
7a. BIRTHPLACE (State or foreign country) <i>Minnesota</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i>			
10. CITY OR TOWN OF DEATH <i>Kensington</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>3522 Nimitz Rd. Kensington Md.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Printer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Kensington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>3522 Nimitz Rd.</i>	
14. FATHER'S NAME First <i>Harry</i> Middle <i>L.</i> Last <i>Colwell</i>			15. MOTHER'S MAIDEN NAME First <i>Esther</i> Middle <i>Inberg</i> Last <i>Inberg</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> <i>WW II</i>			
16b. SOCIAL SECURITY NO. <i>471-16-8354</i>			17. INFORMANT <i>Mrs. Loretta A. Colwell</i>			ADDRESS <i>Kensington, Md. 3522 Nimitz Rd.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary insufficiency</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF <i>artery</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Coronary heart disease</i> (b) <i>Coronary heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Belden R. Reap</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>October 27, 1968</i>			
EXAMINER'S NAME (Type) <i>Belden R. Reap</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
			ADDRESS (Street, city, town, or county) <i>Wheaton, Maryland</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10-30-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Prince Georges, Maryland</i>			
24. FUNERAL DIRECTOR <i>J.W. Lee</i>				ADDRESS <i>Sil. Spr. Md.</i>		25a. REC'D BY REGISTRAR DATE <i>OCT 31 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
26. FUNERAL HOME <i>Warner E. Pumphrey, Inc. 8434 Ga. Avenue</i>									

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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WYOMING EXAMINER'S CERTIFICATE OF QUALITY

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WYOMING EXAMINER'S CERTIFICATE OF QUALITY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED NAME (Type or print) <b>JOHN FRANCIS CONLON</b>						2a. DATE OF DEATH <b>Oct</b> Month <b>6</b> Day <b>1968</b> Year			2b. HOUR <b>10 20 A-M</b>				
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>5-4-1911</b>			6. AGE (In years last birthday) <b>57</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		
7a. BIRTHPLACE (State or foreign country) <b>California</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince George's</b> <b>Montgomery</b> Md.						
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington San. &amp; Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Administrative Ass't.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Senator</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince Georges Chillum</b>			13c. CITY OR TOWN <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13d. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>				13e. STREET AND NUMBER <b>6604 Karlson Court</b>	
14. FATHER'S NAME First <b>Patrick Francis</b> Middle <b>Conlon</b> Last <b>Conlon</b>				15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Burke</b> Last <b>Burke</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>yes</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>503-07-4936</b>			17. INFORMANT Address <b>Mrs. Alberta N. Conlon, Wife, same as #13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b>													
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b>													
DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 years</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <b>4201</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 1962, to <b>Oct</b> , 1968, that (I) (we) last saw the deceased alive on <b>9/11</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>J.E. Fitzgerald</b>						DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) <b>J.E. Fitzgerald</b>						22e. ADDRESS <b>3750 Reservoir Rd NW</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Burial</b>			23b. DATE <b>10-9-1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Palm Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Las Vegas, Nevada</b>				
24. FUNERAL DIRECTOR <b>Joseph Carler's Sons, Inc.</b>						ADDRESS <b>5130 Wisc. Ave. N.W., Wash., D.C., 20016</b>			25a. REC'D BY REGISTRAR <b>DATE OCT 10 1968</b>				
									25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				



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UNITED STATES OF AMERICA

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OFFICE OF THE SECRETARY OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14580

14588

1. DECEASED-NAME (Type or print) <b>Ann</b>			First Middle Last <b>(NMN) Corbley</b>			2a. DATE OF DEATH Month Day Year <b>October 9 1968</b>			2b. HOUR AM PM <b>4:45 M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>February 14, 1905</b>			6. AGE (In years last birthday) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b> Md.					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center, NIH</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Saleslady: Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Retail Mdse</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Chevy Chase</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6704 Hillandale Road</b>					
14. FATHER'S NAME First Middle Last <b>Charles Blume</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Pearl Redd</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>			16b. SOCIAL SECURITY NO. <b>104-07-0011</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Md. 20014</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute and chronic respiratory failure secondary to chronic bronchitis and emphysema</b> <b>180X</b> DUE TO, OR AS A CONSEQUENCE OF <b>Generalized peritonitis secondary to ileal loop perforation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>DUE TO, OR AS A CONSEQUENCE OF Advanced recurrent carcinoma of the cervix - post-operative total pelvic exenteration</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>40 days</b> <b>2 weeks</b> <b>7 months</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>171X</b>												
19a. DATE OF OPERATION <b>8/26/68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of cervix</b>			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 11</b> , 19 <b>68</b> , to <b>October 9</b> , 19 <b>68</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>October 9</b> , 19 <b>68</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.												
22b. SIGNATURE <b>Peter J. Deckers M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/9/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Peter J. Deckers, M.D.</b>				22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/14/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat'l Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Baltimore, Md.</b>					
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>				7557 Wisconsin Ave. ADDRESS		25a. REC'D BY REGISTRAR <b>OCT 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

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## CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Pearl			Jean		COX	10 21 1968			1:45A M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female		Cauc		3 Feb 1926			42 YRS.		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Michigan		USA					Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Naval Hospital			Purchasing Agent			Navy Exchange		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland						Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4919 Frederick Ave.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Arthur Tourtellote											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT					
no				214 20 6062		John H. COX 4919 Frederick Ave. Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the breast with widespread metastases</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (A) (this hospital) attended the deceased from <u>26 September 68</u> , to <u>21 October 1968</u> , that (X) (we) lost the deceased alive on <u>21 October 1968</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.											
22b. SIGNATURE <u>W. J. Fouty</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 22 Oct. 1968			
22d. PHYSICIAN'S NAME (Type) W. J. FOUTY, M. D.						22e. ADDRESS Naval Hospital, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			Oct. 24, 1968		Baltimore National Cemetery			Baltimore, Md.			
24. FUNERAL DIRECTOR ADDRESS Truman Schwab Funeral Home, Baltimore, Md.						25a. REC'D BY REGISTRAR DATE OCT 25 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14590

1. DECEASED-NAME (Type or print) First Middle Last <i>Larry Johnson Creeger Jr</i>			2a. DATE OF DEATH Month <i>10</i> Day <i>17</i> Year <i>68</i>		2b. HOUR <i>10:58</i> M			
3. SEX <i>male</i>	4. RACE <i>white</i>		5. DATE OF BIRTH <i>10-17-68</i>		6. AGE (In years last birthday) YRS. MONTHS DAYS <i>— — —</i>	IF UNDER 1 YEAR MONTHS DAYS <i>— —</i>	IF UNDER 24 HRS. HOURS MIN. <i>5 6</i>	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery Co., Md.</i>		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased admission) STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Rt 1 Box 261</i>
14. FATHER'S NAME First Middle Last <i>Larry Johnson Creeger</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Linda Sue Golden</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Birth Certificate</i>		Address		

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART 1. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

*Pulmonary atelectasis*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) *Immaturity*

DUE TO, OR AS A CONSEQUENCE OF

(c)

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

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MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>9:00 AM, 10/18/68</i> to <i>11:00 AM, 10/18/68</i> , that (I) (we) last saw the deceased alive on <i>10/18/68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Joseph G. Dugan, M.D.</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>10/17/68</i>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS <i>50 W. Edmonston Dr. - Rockville Md.</i>			

23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>10/17/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Suburban Hospital</i>		23d. LOCATION (City or Town) (County) (State) <i>Bethesda - Montg. - MD.</i>	
24. FUNERAL DIRECTOR <i>Mrs. Amelia S. Carter, Administrator</i>				25a. REC'D BY REGISTRAR <i>ACT 23 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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RECORDS OF THE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheets 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14583

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14591

1. DECEASED-NAME (Type or print) <i>Joseph T Crivella</i>			2a. DATE OF DEATH Month <i>October</i> Day <i>31</i> Year <i>1968</i>			2b. HOUR <i>12 AM</i>			
3. SEX <i>MALE</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>JAN 3, 1896</i>		6. AGE (In years last birthday) <i>72</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Italy</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>SUBURBAN Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Chevy Chase</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4607 Elm. St.</i>	
14. FATHER'S NAME First <i>Nunzio</i> Middle <i>Crivella</i> Last <i>Crivella</i>			15. MOTHER'S MAIDEN NAME First <i>CIRENO</i> Middle <i>ROSARA</i> Last <i>ROSARA</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>578-01-7465</i>		17. INFORMANT <i>John Joseph</i>		Address <i>Same as above</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory insufficiency</i> <i>492x</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>527.7</i> (b) <i>Pulmonary edema and pleural effusion</i> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Emphysema and pleural fibrosis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>10/1/68</i> , 19 <i>68</i> , to <i>Oct. 31</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Oct. 30</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>V.C. de Guzman MD</i>					22c. DATE SIGNED <i>10-31-68</i>				
22d. PHYSICIAN'S NAME (Type) <i>VICENTE C. DE GUZMAN MD</i>					22e. ADDRESS <i>1234 19 NW WASH DC</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>Nov. 4, 68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt Olivet Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Washington, D. C.</i>			
24. FUNERAL DIRECTOR <i>Robert A Pumphrey</i>					25a. REC'D BY REGISTRAR DATE <i>NOV 6 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14584		CERTIFICATE OF DEATH								14592	
1. DECEASED-NAME (Type or print) <i>Richard Cromwell</i>						2a. DATE OF DEATH Month <i>10</i> Day <i>31</i> Year <i>1968</i>			2b. HOUR <i>1:58 PM</i>		
3. SEX <i>m</i>		4. RACE <i>caucasian</i>		5. DATE OF BIRTH <i>4/20/1888</i>		6. AGE (in years last birthday) <i>88</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Buckeaton</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Cohasset</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Oronoco Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Electrician</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>De.</i>				13b. COUNTY <i>Wash.</i>		13c. CITY OR TOWN <i>Wash.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4607 Conn. Ave. NW</i>	
14. FATHER'S NAME First <i>Arthur</i> Middle <i>Cromwell</i> Last				15. MOTHER'S MAIDEN NAME First <i>Christie</i> Middle <i>Trundle</i> Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <i>215-67-3611</i>		17. INFORMANT <i>G. Arthur Cromwell</i>				Address <i>Same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of bladder</i> <i>188X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1910 Arteriosclerotic Cardiovascular disease</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>8/10</i> , 19 <i>68</i> , to <i>10/31</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10/31</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Myron L. Lenker</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>10/31/68</i>			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>11/2/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Monacacy</i>		23d. LOCATION (City or Town) (County) (State) <i>Beallsville Montg. Md.</i>					
24. FUNERAL DIRECTOR <i>William B. Hillen Barnesville</i>						25a. REC'D BY REGISTRAR DATE <i>NOV 6 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION

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RECEIVED OF BIRTH

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 22a Film 407 Maryland State Department of Health  
11-25-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14593

14585

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) <b>(Theresa) Teresa Marie Cuozzo</b>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>10</b> Day <b>19</b> Year <b>1968</b> 40A	
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>1-4-95</b>	6. AGE (In years last birthday) <b>73</b> YRS
7a. BIRTHPLACE (State or foreign country) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>America</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Sanitarium</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Prince George</b>		13b. CITY OR TOWN <b>Hyattsville</b>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME <b>(Luigi) Louis Rubino</b>		15. MOTHER'S MAIDEN NAME <b>Carmela Tantalena</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Patient's chart</b>		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>466X</b> <b>acute tracheo-bronchitis with secondary pulmonary atelectasis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>lost 500X</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>lost 500X</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>11/19/68</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <b>19</b>	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Peap</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. PEAP M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10.22.68</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home. 300.4th st N E</b>		25a. REC'D BY REGISTRAR <b>10/19/1968</b>	
ADDRESS <b>Wash D C</b>		25b. REGISTRAR'S SIGNATURE <b>10/19/1968</b>	

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Body released by Dr. Reap.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14586

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14594

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>Joseph Samuel Dagenhart</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>22</b> Year <b>68</b>			2b. HOUR A.M. or P.M. <b>4:50</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>9-11-07</b>		6. AGE (In years last birthday) <b>61</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hos.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Orthopedic Tech.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Gov't.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Sil. Spr.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>11235 Oakleaf Drive</b>							
14. FATHER'S NAME First Middle Last <b>Charles Edward Dagenhart</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Bertha May Myers</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>578-32-4584</b>		17. INFORMANT Address <b>Mildred B. Dagenhart-11235 Oakleaf Drive</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4221</b> (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>Hypercholesterolemia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1966</b> , to <b>Oct. 22, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct. 15, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Fredrick Moorman M.D.</b>				22c. DATE SIGNED <b>Oct. 22, 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>Medical Center, Sandy Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Oct. 26, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Md.</b>	
24. FUNERAL DIRECTOR <b>Arthur Waters Washington, D.C. 20012</b>		25a. REC'D BY REGISTRAR <b>OCT 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with Medical Examiner

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month 10 Day 13 Year 68		2b. HOUR 2:00P				
3. SEX male		4. RACE caucasian		5. DATE OF BIRTH 7/29/89		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Washington, DC.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) machinist		12b. KIND OF BUSINESS OR INDUSTRY Govt.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Sp.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9110 Providence Avenue			
14. FATHER'S NAME Robert		First Middle Last Dalkin		15. MOTHER'S MAIDEN NAME Margaret		First Middle Last Morton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. YES		17. INFORMANT Aileen G. Dalkin		Address 9110 Providence					
				<del>Mr. John Stamp, son in law</del>		<del>Ave. S.S., Md.</del>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 - SUDDEN DEATH Several years " "			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Diabetes Mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from July 5, 1955, to Oct. 13, 1968, that (I) (we) last saw the deceased alive on Sept. 19, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Lawrence D. Summerfield MD.		22c. DATE SIGNED 10-14-68		22d. PHYSICIAN'S NAME (Type) LAWRENCE D. SUMMERFIELD M.D.		22e. ADDRESS 3230 Pa. Ave S.E. WASHINGTON D.C. 20020					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-17-1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland P.G. Md.					
24. FUNERAL DIRECTOR Warner E. Humphrey, Inc.		24b. ADDRESS 8434 Ga. Ave. S.S., Md.		25a. REC'D BY REGISTRAR OCT 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

14555

14587

RECEIVED 14587

14555

14588

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>GEORGE</b>			First Middle Last <b>DANN</b>			2a. DATE OF DEATH <b>10</b> Month <b>18</b> Day Year <b>1968</b>			2b. HOUR <b>9:52 PM</b>		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>1/15/1900</b>			6. AGE (In years lost birthday) <b>68</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Poland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b>		
10. CITY OR TOWN OF DEATH <b>Silver Spring, Md.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Merchant</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Silver Spring</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>2305 Westview Dr</b>			14. FATHER'S NAME First Middle Last <b>Abraham Dann</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Chaya Weiss</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>578-46-8781</b>			17. INFORMANT Address <b>Harry Wolfe, Son-in-law</b>			2305 Westview Dr S.S.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>G.I. Hemorrhage</b> <b>5310</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>5420</b> (b) <b>Peptic ulcer</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Hypertension &amp; arteriosclerosis Heart disease</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1968</b> , to <b>present</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>Oct. 14</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <b>did</b> (did not) view the body after death.											
22b. SIGNATURE <b>Abraham W. Danzansky</b>			DEGREE <b>MD</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>10-18-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>ABRAHAM W. DANZANSKY</b>			22e. ADDRESS <b>1106 SPRING ST</b>			22f. ADDRESS <b>SS. 248</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>10/20/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Ohev Sholom Talmud</b>			23d. LOCATION (City or Town) (County) (State) <b>Capital Heights, Md.</b>		
24. FUNERAL DIRECTOR <b>Bernard Danzansky and Sons</b>			25a. REC'D BY REGISTRAR <b>3501 14th St., N.W. Wash., D.C.</b>			25b. REGISTRAR'S SIGNATURE <b>Oct 23 1968</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

58621



Cleared with Dr. Kemp.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14589		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14597	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) Emma Beaulieu Darling			2a. DATE OF DEATH Oct. 23 1968			2b. HOUR 12:25 P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8-4-1880		6. AGE (In years last birthday) 88 YRS.	
7a. BIRTHPLACE (State or foreign country) Vermont		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7705 Eastern Ave.	
14. FATHER'S NAME First Middle Last Ludger Ludger Beaulieu			15. MOTHER'S MAIDEN NAME First Middle Last Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 213-38-3843		17. INFORMANT Fitzgerald John Fitzgerald nephew Address: 5231 Woodside Pkwy. Sil. Spr. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 acute myocardial infarct DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hr							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from July 1965, to 10-23-1968, that (I) (we) last saw the deceased alive on 10-21-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. J. Sengstack, MD				22c. DATE SIGNED 10-23-68			
22d. PHYSICIAN'S NAME (Type) G. J. Sengstack, MD				22e. ADDRESS 9341 Columbia Blvd. S. S. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Oct. 28, 1968		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Virginia	
24. FUNERAL DIRECTOR M. Andrew Duwall Warner E. Humphrey, Inc., 8434 Ga. Ave., Md.				25a. REC'D BY REGISTRAR DATE OCT 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

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# FOR STATE HEALTH DEPT.

14590

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14598

1. DECEASED-NAME (Type or Print)		First CHARLES		Middle L.	Last DASHER, JR.		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month 10 Day 31 Year 1968		2b. HOUR 6:45 PM		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH JULY 11, 1900	6. AGE (In years last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 10 Day 31 Year 1968		2d. HOUR 4:55 PM	
7a. BIRTHPLACE (State or foreign country) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7812 Old Chester Road				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RET. - MAJ. GEN.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Army			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7812 OLD CHESTER ROAD			
14. FATHER'S NAME First CHARLES		Middle L.		Last DASHER, SR.		15. MOTHER'S MAIDEN NAME First ELOISE		Middle -		Last WILDER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		(If yes give year or dates of service) WWII + KOREA		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS HELEN R. DASHER - SAME AS #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Cardio Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Years</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		JOHN G. BALL				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)		22b. DATE SIGNED Oct 31, 1968 MONTG. CO., MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 11/4/68		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT. CEM.		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VA.					
24. FUNERAL DIRECTOR JOS. GAWLEN'S SONS, 5130 WIS. AVE, WASH., D.C.				ADDRESS		25a. REC'D BY REGISTRAR DATE NOV 7 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the form. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

666

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 6 Film 406 11/1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14591

CERTIFICATE OF DEATH

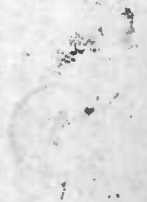
14599

1. DECEASED-NAME (Type or print) <b>HALLIE LEE DASHIELL</b>			2a. DATE OF DEATH Month <b>October</b> Day <b>16</b> Year <b>1968</b>			2b. HOUR <b>9<sup>22</sup> A M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>1-11-92</b>		6. AGE (In years last birthday) <b>76<sup>15</sup> YRS.</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>American</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Sanatorium Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>none</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>MONT</b>		13c. CITY OR TOWN <b>Takoma Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>407 Browning Court</b>							
14. FATHER'S NAME First <b>Robert</b> Middle <b>Hornsby</b> Last <b>Willing</b>			15. MOTHER'S MAIDEN NAME First <b>Florence</b> Middle <b>Willing</b> Last <b>Willing</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>215-54-8309</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL INFARCT (36 hr)</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY ARTERY DISCRETE (See 4109)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>CHF, Diabetes mellitus, Olyuria 2° to shock.</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 hr</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>10-14</b> , 19 <b>68</b> , to <b>10-16</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-16</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John L. Ford MD</b>				22c. DATE SIGNED <b>10-16-68</b>		22d. PHYSICIAN'S NAME (Type) <b>JOHN LOUIS FORD, M.D.</b>	
22e. ADDRESS <b>831 UNIVERSITY BLVD E. SILVER SPRING MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10-18-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MANOKIN PRES. CEM</b>		23d. LOCATION (City or Town) (County) (State) <b>PRINCESS ANNE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale, Md</b>				25a. REC'D BY REGISTRAR <b>OCT 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

14289

CENTRAL OF DEATH

14289





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

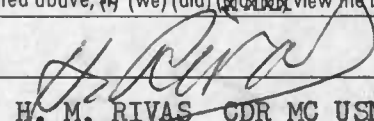

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14592

CERTIFICATE OF DEATH

14600

1. DECEASED-NAME (Type or print) <b>Helen</b>			First <b>H.</b> Middle <b>DAWSON</b> Last			2a. DATE OF DEATH <b>OCT</b> Month <b>17</b> Day Year <b>68</b>			2b. HOUR <b>925P</b>		
3. SEX <b>Female</b>			4. RACE <b>Caucasian</b>			5. DATE OF BIRTH <b>July 28, 1898</b>			6. AGE (In years last birthday) <b>70</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b> Md.		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>			13c. CITY OR TOWN <b>Annapolis</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>35 Southgate</b>			14. FATHER'S NAME First <b>Thomas H.</b> Middle <b>Hunt</b> Last			15. MOTHER'S MAIDEN NAME First <b>Beulah Elizabeth</b> Middle <b>Haines</b> Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Annapolis</b> Address <b>Md</b> <b>Col. Merle B. Dawson, 35 Southgate Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal Hemorrhage</b> <b>5699</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>578X</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Sept. 3, 1968</b> , to <b>October 17, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 17, 1968</b> , and that in <b>(our)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (we) (did) (did not) view the body after death.											
22b. SIGNATURE  H. M. RIVAS CDR MC USN						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>Oct. 18, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>H. M. RIVAS</b>						22e. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>			23b. DATE <b>10-21-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Arlington Va.</b>		
24. FUNERAL DIRECTOR <b>John M. Taylor Funeral Home</b> <b>147-149 Gloucester St. Annapolis, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 22 1968</b>			25b. REGISTRAR'S SIGNATURE 		

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**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-100. 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) <i>Germaine Norma Kelp</i>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <i>10/28 1968</i>			2b. HOUR <i>?</i> M <i>P</i>		
3. SEX <i>F</i>	4. RACE <i>W.</i>	5. DATE OF BIRTH <i>Feb 21, 1901</i>	6. AGE (In years last birthday) <i>67</i> YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month <i>Oct</i> Day <i>27</i> Year <i>1968</i>		
7a. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Bethesda.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>5815 Kingswood Rd.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Inspector-Govt</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda.</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>5815 Kingswood Rd.</i>	
14. FATHER'S NAME First <i>Claude L.</i> Middle <i>Starnes</i> Last <i></i>			15. MOTHER'S MAIDEN NAME First <i>Carrie E.</i> Middle <i>Hill</i> Last <i></i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i></i>			17. INFORMANT <i>Brother</i> ADDRESS <i>Julian Starnes- Same as Item 13.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) <i>Intra-cerebral hemorrhage, left, massive.</i>								
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral arteriosclerosis &amp; hypertension.</i>								
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>331X</i>								
19a. DATE OF OPERATION <i></i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i></i>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>19</i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i></i>		21f. LOCATION Street or R.F.D. No. <i></i>		City or Town <i></i>		County <i></i> State <i></i>
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John G. Ball</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <i>Oct 28, 1968</i>		
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10-21-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Natl Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Arlington, Virginia</i>		
24. FUNERAL DIRECTOR ADDRESS <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR DATE <i>NOV 4 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-58

14594		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14602	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) <i>John A. Dickinson</i>			2a. DATE OF DEATH Month <i>October</i> , Day <i>4</i> , Year <i>1968</i>			2b. HOUR <i>9:50 P M</i>	
3. SEX <i>Male</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH <i>Sept. 4, 1889</i>		6. AGE (In years last birthday) <i>79</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>5525 Charles St.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Mech. Eng. - Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>5525 Charles St.</i>		14. FATHER'S NAME First <i>John W.</i> Middle <i>Dickinson</i> Last <i>Dickinson</i>		15. MOTHER'S MAIDEN NAME First <i>Foster</i> Middle <i>Foster</i> Last <i>Foster</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>213-42-7610</i>		17. INFORMANT <i>Wife</i> Address <i>Same as Item 13</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pulmonary edema, acute</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>congestive cardiac failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>atherosclerotic cardiac disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4344 Diabetes mellitus</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 hours</i> <i>1 week</i> <i>5 + years</i>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct. 4, 1968</i> , to <i>Oct. 4, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct. 4, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Alban W. Egger, M.D.</i>				22c. DATE SIGNED <i>10/4/1968</i>		22d. PHYSICIAN'S NAME (Type) <i>Alban W. Egger, M.D.</i>	
22e. ADDRESS <i>1801 Eye St. N.W., Washington</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>10-5-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i>	
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>OCT 11 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



14603

14603

STATE OF TEXAS

Sept. 4, 1963

Gov.

Mr.

New Jersey

Bedford

Bedford County, Pennsylvania

John F. Dickinson

215-2-7010

Continuation 10-2-68

Bedford, Pa.

Oct 11 1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Items 1 & 13 taken from birth certificate											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>Frederick BABI/BOY Edward Doeblor</b>						2a. DATE OF DEATH Month <b>October</b> Day <b>12</b> Year <b>1968</b>			2b. HOUR <b>4:15 P.M.</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>October 10, 1968</b>		6. AGE (In years last birthday) <b>2</b> YRS.		IF UNDER 1 YEAR MONTHS <b>2</b> DAYS <b>12</b> HOURS <b>8</b> MIN.		IF UNDER 24 HRS. HOURS <b>12</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>					
10. CITY OR TOWN OF DEATH <b>Olney</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Montgomery General Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>none</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Derwood</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>7617 Dew Wood Drive</b>		
14. FATHER'S NAME First <b>Charles</b> Middle <b>E</b> Last <b>Doeblor</b>				15. MOTHER'S MAIDEN NAME First <b>Marilyn</b> Middle <b>Lee</b> Last <b>McDermott</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>			
16b. SOCIAL SECURITY NO.				17. INFORMANT <b>Admission Rec'd., Montgomery General Hospital</b>				Address <b>Olney, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic meningitis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>742 X</b> (b) <b>Hydrocephalus - congenital</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>752 X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 10, 1968</b> , to <b>Oct. 12, 1968</b> , that (I) (we) lost saw the deceased alive on <b>Oct. 12, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Katharine A. Chapman, M.D.</b> DEGREE <b>M.D.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Oct. 12, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>KATHARINE A. CHAPMAN</b>						22e. ADDRESS <b>3924 Baltimore Ave., Kensington Md.</b>					
23a. BURIAL (CREMATION) REMOVAL (Specify)		23b. DATE <b>10.15.68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>V. Md. Med. School</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>TYSON WHEELER ROCKVILLE, MD.</b>			
24. FUNERAL DIRECTOR <b>TYSON WHEELER ROCKVILLE, MD.</b>						25a. REC'D BY REGISTRAR <b>OCT 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

MEDICAL CERTIFICATION

81-27439

16803

16803



**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil, in lieu of. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14596

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14604

1. DECEASED-NAME (Type or Print)			First <i>JESSE</i>			Middle <i>GEORGE</i>			Last <i>DORSEY</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>Oct</i> Day <i>12</i> Year <i>1968</i>			2b. HOUR <i>8:30</i> M		
3. SEX <i>M.</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>MAY 31 - 09</i>		6. AGE (In years last birthday) <i>59</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month <i>Oct</i> Day <i>12</i> Year <i>1968</i>			2d. HOUR <i>8:30</i> M		
7a. BIRTHPLACE (State or foreign country) <i>GAITHERSBURG</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i>								
10. CITY OR TOWN OF DEATH <i>German town</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Highway 70 S.</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>BLD RAIL ROAD</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>				13b. COUNTY <i>Montgomery</i>				13c. CITY OR TOWN <i>GAITHERSBURG</i>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Rt. # 3</i>			
14. FATHER'S NAME First <i>JOHN</i> Middle <i>H.</i> Last <i>DORSEY</i>						15. MOTHER'S MAIDEN NAME First <i>Dora</i> Middle <i>Payne</i> Last <i>Payne</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>						16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT <i>Sister</i> ADDRESS <i>MARIAN DORSEY</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Injuries Severe</i> <i>814.7</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Trauma from being struck by Auto</i> DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden.</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>1124</i>																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year <i>8:20 P.M. Oct 12 1968</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Pedestrian. Struck by car on Highway</i>									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Highway</i>				21f. LOCATION Street or R.F.D. No. City or Town County State <i>Highway 70 S German town Montgomery, Md.</i>									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <i>John S. Bell</i>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED <i>Oct 12, 1968</i>					
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>				23b. DATE <i>10-16-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Emory Grove Cem.</i>				23d. LOCATION (City or Town) (County) (State) <i>GAITHERSBURG, MONTG. MD.</i>							
24. FUNERAL DIRECTOR <i>Robert L. Snowden</i>						ADDRESS <i>Rockville, Md.</i>						25a. REC'D BY REGISTRAR DATE <i>OCT 15 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Bessie</b> First <b>Dragoo</b> Middle <b>Catherine</b> Last			2a. DATE OF DEATH <b>October</b> Month <b>6</b> Day <b>1968</b> Year			2b. HOUR <b>4:30</b> P.M.	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Dec 20, 1899</b>		6. AGE (In years last birthday) <b>68</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Garrett, Ill.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. San &amp; Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Ill.</b> COUNTY <b>Champaign</b>		13c. CITY OR TOWN <b>Champaign</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1303-South Elm Street</b>	
14. FATHER'S NAME First <b>Marion</b> Middle <b>Revell</b> Last			15. MOTHER'S MAIDEN NAME First <b>Lucy</b> Middle <b>Reeves</b> Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>337-20-8766</b>		17. INFORMANT <b>Hyattsville, Md.</b> Address <b>Don Dragoo 2100 Charleston Place</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>4201</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>6 mo</b> <b>6 months</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/7/68</b> , 19 <b>68</b> , to <b>9/26</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>9/26</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Maurice A. Capone, MD</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/7/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>MAURICE A. CAPONE, M.D.</b>				22e. ADDRESS <b>Georgetown Hospital, Wash. D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 10, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Lawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Champaign, Illinois</b>	
24. FUNERAL DIRECTOR <b>C. G. Carter &amp; Sons, Inc. 8434 Ga. Ave. Sil. Spg.</b>				25a. REC'D BY REGISTRAR <b>OCT 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in with general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14606	
Item 23c Film 406 10-22-1968										14598	
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <b>GEORGE D DRECHSLER</b>					2a. DATE OF DEATH Month Day Year <b>OCT 19 1968</b>					2b. HOUR <b>10 45 AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>6/18/98</b>			6. AGE (In years last birthday) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>WASHINGTON, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.					
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SUBURBAN</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Ball of mines</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>GOUT</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>CHRY CHASE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>7420 LYNNHURST ST.</b>		
14. FATHER'S NAME First Middle Last <b>EDWARD DRECHSLER</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>CLARA ANDREWS</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>705-05-0175</b>		17. INFORMANT <b>(WIFE)</b>			Address <b>MARGARETTA DRECHSLER - SAME</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pylonephritis</b> <b>5901</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Pylonephritis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>6000 Coronary Arteriosclerosis, severe</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>9/22, 1968</b> , to <b>10/19, 1968</b> , that (I) (we) last saw the deceased alive on <b>10/18, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>H.P. Dorman MD</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/19/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>H.P. Dorman</b>						22e. ADDRESS <b>1302 18TH ST. N.W., WASH., D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>10-22-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Olivet Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>St. Michaels, Maryland</b>			
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</b>						25a. REC'D BY REGISTRAR <b>OCT 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>O. Charles Jones</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tobacco papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14599									
CERTIFICATE OF DEATH									
14607									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Boy			DREW			10 Month 29 Day 1968 Year			2:50 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		WHITE		10/29/68		— YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
MARYLAND		U.S.A.				MONTGOMERY			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
BETHESDA			SUBURBAN Hospital						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MARYLAND			MONTGOMERY			GAITHERSBURG		13e. STREET AND NUMBER	
								1 WATER STREET	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
			ELAINE ELIZABETH DREW						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
						MOTHER SAME AS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH CAUSED BY:									
IMMEDIATE CAUSE (a) complete abortion (22 weeks gestation)									
773X DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
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19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Joseph Surdine									
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
10/29/68			SUBURBAN Hospital		Bethesda Montg. Md.				
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Mrs. Amelia C. Carter						DATE NOV 1 1968		Charles Judge	

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## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Freddie Hirschel DUKE</b>			2a. DATE OF DEATH Month <b>OCT</b> Day <b>6</b> Year <b>68</b>			2b. HOUR <b>140P</b> M				
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Mar 24, 1934</b>		6. AGE (In years last birthday) <b>34</b> YRS.		IF UNDER 1 YEAR MONTHS <b>34</b> DAYS <b>34</b> HOURS <b>34</b> MIN		
7a. BIRTHPLACE (State or foreign country) <b>Louisiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.				
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>U. S. Navy</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Louisiana</b>			13b. COUNTY <b>Vernon</b>		13c. CITY OR TOWN <b>Leesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Route 4, Box 112</b>	
14. FATHER'S NAME First <b>John H.</b> Middle <b>Duke</b> Last			15. MOTHER'S MAIDEN NAME First <b>Fredda</b> Middle <b>Enoch</b> Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b> (If yes give war and dates of service) <b>1954-68</b>			16b. SOCIAL SECURITY NO. <b>437 46 9137</b>		17. INFORMANT <b>Navy Records</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UNDIFFERENTIATED SARCOMA WITH METASTASES</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO, OR AS A CONSEQUENCE OF lost. (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1992</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <b>August 17, 1968</b> , to <b>Oct. 6, 1968</b> , that (X) (we) last saw the deceased alive on <b>Oct. 6, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>R. D. Gaskins</b>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>7 Oct. 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>R. D. GASKINS, M. D.</b>					22e. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-11-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Jasper Texas</b>			
24. FUNERAL DIRECTOR <b>W. W. Chambers Co.</b> <b>1400 Chapin St., N. W. Washington, D. C.</b>					25a. REC'D BY REGISTRAR <b>OCT 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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14808

14808





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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14601

CERTIFICATE OF DEATH

14609

1. DECEASED-NAME (Type or print) <b>DELLA</b> First <b>NMN</b> Middle <b>DUNHAM</b> Last			2a. DATE OF DEATH <b>10</b> Month <b>11</b> Day <b>68</b> Year			2b. HOUR <b>9:45</b> P. M.					
3. SEX <b>Female</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>3/18/93</b>		6. AGE (In years last birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>CANADA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.					
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASHINGTON SAN. &amp; HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>NSW</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>TAKOMA PARK</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6607 Westmoreland Ave.</b>		
14. FATHER'S NAME First <b>John</b> Middle <b>r</b> Last <b>McIntyre</b>			15. MOTHER'S MAIDEN NAME First <b>Christina</b> Middle <b>McKennon</b> Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Hospital Records</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4519 ACUTE Pulmonary Embolus</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PHLEBO THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b> <b>DAYS</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>466X CARCINOMA OF LIVER</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>10-8</b> , 19 <b>68</b> , to <b>10-11</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-11</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Samuel T. Kimblich M.D.</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10-11-68</b>			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS <b>9801 Georgia Ave. Silver Spring</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Oct. 15, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Md</b>					
24. FUNERAL DIRECTOR <b>John Walters, 254 Carroll Blvd. HC</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

14609

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14609

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
14602										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR	
LESLIE			L. EARP			OCT 3 1968			8A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
MALE		WHITE		8/13/21		47 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Washington, DC		U.S.A.				MONTGOMERY Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA			SUBURBAN			ASST MANAGER			PHILIPS-ROBERTS	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET AND NUMBER			
MARYLAND			Rockville		YES <input type="checkbox"/> NO <input type="checkbox"/>		4413 HALLET ST.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
JOHN N. EARP			Bedia CORNELL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
yes			WW II		MILDRED EARP - WIFE - SAME.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Peritonitis diffuse</u>										
5770 DUE TO, OR AS A CONSEQUENCE OF										
(b) <u>pancreatic abscess</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
<u>Intestinal Hemorrhage due to superficial gastric ulceration.</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 7, 1968</u> , to <u>OCT 3, 1968</u> , that (I) (we) lost saw the deceased alive on <u>OCT 3, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE				DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
<u>P.P. Andrews M.D.</u>						<input checked="" type="checkbox"/>				<u>10-3-68</u>
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
<u>P.P. ANDREWS M.D.</u>				<u>WASHINGTON D.C.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)	
<u>BURIAL</u>		<u>10-5-1968</u>		<u>FORT LINCOLN CEMETERY</u>		<u>BLADENSBURG,</u>		<u>PRINCE GEORGES</u>		
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<u>JOSEPH CAWLER'S SONS, INC.,</u>				<u>5130 WISC. AVE.</u>		DATE		<u>OCT 7 1968</u>		
<u>N.W., WASH., D.C., 20016</u>								<u>Charles Judge MD.</u>		

14610

OFFICE OF CLERK

11611

11611

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1514  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
INEZ			L. EATON			Month 5, Day 5, 1968		8:15 A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Female		Cauc.		Mar. 22, 1879		89 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Penna.		U. S.				Montgomery Md.				
1d. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Boysd			Boysd Nursing Home			Housewife				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
District of Col.			--		Washington				Northampton St., N.W.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Unknown			Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT					
No			Unknown		Dorothy Eaton					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Bronchial Pneumonia										
DUE TO, OR AS A CONSEQUENCE OF										
(b) Pulmonary Emphysema										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Generalized Arterio Sclerosis										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year								
		P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from June 1, 1966, to Oct 5, 1968, that (I) (we) last saw the deceased alive on Oct 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)						
Gordon Mardock Smith MD		5 Oct 68		Gordon Mardock Smith MD						
22e. ADDRESS		22f. ADDRESS								
		Barnesville, Md 20703								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Cremation		10-7-68		Cedar Hill Crematory		Suitland, Maryland				
24. PHYSICIAN'S NAME (Type)		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
ROBERT A. PUMPHREY, Bethesda, Maryland		DATE OCT 9 1968		Charles Judge						



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July 2, 1961

NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

14606

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14612

1. DECEASED NAME (Type or print) First Middle Last <b>HELEN F. Egleston</b>			2a. DATE OF DEATH Month Day Year <b>10 11 1968</b>			2b. HOUR <b>3:00 P. M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>6-11-76</b>		6. AGE (In years last birthday) <b>92 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Iowa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b>			
10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Bethesda-Silver Spring Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PUBLIC SCHOOLS</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>WASH. DC</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>WASH. D.C.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2853 Ontario Rd, NW</b>	
14. FATHER'S NAME First Middle Last <b>HENRY CLAY Fletcher</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Delia ANNE CAMP</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b>		(If yes give war or dates of service) <b>-</b>		16b. SOCIAL SECURITY NO. <b>786-62-3798</b>		17. INFORMANT <b>MRS. BARBARA HORSKY</b> Address <b>1227 PINECREST Ct SILVER SPRING</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF <b>Chronic arteriosclerotic heart disease, congestive failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4201</b> DUE TO, OR AS A CONSEQUENCE OF <b>Old healed myocardial infarction</b> Approximate interval between onset and death <b>Sudden</b> <b>One year</b> <b>1965</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Generalized arteriosclerosis</b>									
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>December, 1950</b> , to <b>Oct. 11, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct. 4, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Arnold Mc Nitt, M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10-11-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Arnold Mc Nitt</b>				22e. ADDRESS <b>1835 Eye St., N.W.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>Oct. 11, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince George Co., Maryland</b>			
24. FUNERAL DIRECTOR <b>WALTER E. Pumphrey</b>		ADDRESS <b>8434 CA AVE. S.S.</b>		25a. REC'D BY REGISTRAR <b>OCT 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

Hubbard

7/10/1910

1

Old World Hypocistidae

*Stenotaphrum secundatum*

December 30 (Sat) 11:00-12:00

83-11-01

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34

Am. Hist. Mus.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14605									
14613									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <i>Mylos W. English</i>			2a. DATE OF DEATH Month <i>Oct.</i> Day <i>5</i> Year <i>1968</i>			2b. HOUR <i>9:00</i> M			
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>5/29/09</i>		6. AGE (In years last birthday) <i>59</i> YRS.		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>MAINE</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Attorney</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Nat'l Highway</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>5809 - Wilson Lane</i>	
14. FATHER'S NAME First <i>G. Wesley</i> Middle <i>English</i> Last <i>English</i>			15. MOTHER'S MAIDEN NAME First <i>Annie</i> Middle <i>Hemp Hill</i> Last <i>Hemp Hill</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT <i>MARY ENGLISH - WIFE</i> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>Bacteremia &amp; Bronchio Pneumonia</i> 3 days									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bronchio Pleural Fistula Left Lung</i> 2 days									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pulmonary abscess Left Lung</i> 3 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<i>521X Diabetes Mellitus</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1964</i> , to <i>Oct 5</i> , 1968, that (I) (we) last saw the deceased alive on <i>Oct 5</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>DeWitt E. Delawter MD</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <i>10-6-68</i>				
22d. PHYSICIAN'S NAME (Type) <i>DeWitt E. Delawter</i>					22e. ADDRESS <i>3848 Porter St NW WASH D.C.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10-8-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>			
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i> ADDRESS					25a. REC'D BY REGISTRAR <i>OCT 11 1968</i> DATE		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

20341

14614

14608

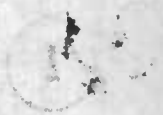
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) <b>JAMES STANLEY FALCK</b>			2a. DATE OF DEATH Month <b>OCT</b> Day <b>15</b> Year <b>1968</b>			2b. HOUR <b>1:40 P.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>APRIL 13, 1881</b>		6. AGE (In years lost birthday) <b>87</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b>	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SUBURBAN</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>PHARMACEUTIST RET. GOVT</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>CHEY CHASE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <b>FREDERICK FALCK</b>		15. MOTHER'S MAIDEN NAME <b>MARGARET BERNETTER SHAFFER</b>		13e. STREET AND NUMBER <b>5613 BELMONT AVE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>MRS. (NIECE) LAURENCE SIMMONS - 4852 BAYARD BLVD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4109</b> IMMEDIATE CAUSE (a) <b>Acute myocardial infarction, septum</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4201</b> (b) <b>Coronary arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Carcinoma, head of pancreas with metastases to lungs and liver</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jun 60</b> , to <b>Oct 15, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 15, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.							
22b. SIGNATURE <b>Michael J. Healy MD</b>		22c. DATE SIGNED <b>10/16/68</b>		22d. PHYSICIAN'S NAME (Type) <b>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</b>		22e. ADDRESS <b>5411 W. Cedar Ln Bethesda Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-18-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</b>		25a. REC'D BY REGISTRAR <b>OCT 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

18014

14003



10-11-1955 - Oak Hill Country Club, Washington, D.C.

10-11-1955 - Oak Hill Country Club, Washington, D.C.

10-11-1955 - Oak Hill Country Club, Washington, D.C.



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is unnecessary, please execute the certificate, writing the word "pending" in pencil in item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&22a Film 406 MARYLAND STATE DEPARTMENT OF HEALTH  
11-19-68ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14607

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14615

1. DECEASED NAME (Type or Print) <b>PAUL AUGUSTINE FEDERLINE</b>		First Middle Last		2a. DATE KNOWN OF DEATH Month <b>10</b> Day <b>25</b> Year <b>1968</b>		2b. HOUR <b>12:45</b>									
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>6-3-17</b>		6. AGE (In years last birthday) <b>51</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>		2c. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>25</b> Year <b>1968</b>		2d. HOUR <b>12:45</b>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b>								Md.	
10. CITY OR TOWN OF DEATH <b>OLNEY</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MONTGOMERY GENERAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>MASONRY FOREMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. CITY <b>MONTGOMERY</b>		13c. STREET AND NUMBER <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <b>1912 NORBECK ROAD</b>							
14. FATHER'S NAME First <b>LOUIS</b> Middle <b>FEDERLINE</b> Last <b>FEDERLINE</b>		15. MOTHER'S MAIDEN NAME First <b>WILAMINA</b> Middle <b>CRAMER</b> Last <b>CRAMER</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>MEDICAL RECORDS</b>		ADDRESS <b>MEDICAL RECORDS</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Bronchopneumonia</b> <b>485X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Bronchitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Emphysema</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>491X</b>															
19a. DATE OF OPERATION <b>10-29-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Chronic Bronchitis</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <b>Bedden Reap</b> EXAMINER'S NAME (Type) <b>BEDDEN REAP, M. D.</b>		M.D. <b>Bedden Reap</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>10/25/1968</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-29-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville Maryland</b>									
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, ROCKVILLE, MARYLAND</b>		ADDRESS <b>ROCKVILLE, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>NOV 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

14412

RECORDS EXAMINER'S CERTIFICATE OF DATA

14401

RAIL ADJUSTIVE FEEDBACK

DATE 1-1-13

RECORDS EXAMINER'S CERTIFICATE OF DATA

14412

RAIL ADJUSTIVE FEEDBACK

14412

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NOV 4 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14608

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14616

1. DECEASED-NAME (Type or print) <del>Kicken</del> Katherine Marie Ficken			2a. DATE OF DEATH Month Day Year OCTOBER 14 1968			2b. HOUR 6:45 P.M.									
3. SEX F		4. RACE W		5. DATE OF BIRTH March 3, 1911		6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.									
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Resmor San. Bethesda, Md.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Architect		12b. KIND OF BUSINESS OR INDUSTRY Building									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Montgom.		13c. CITY OR TOWN Sil. Spr.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 711 Dale Drive					
14. FATHER'S NAME First Middle Last Howard C. Cutler			15. MOTHER'S MAIDEN NAME First Middle Last Marie K. Zahn			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, none (unknown) (If yes give war or dates of service) No						16b. SOCIAL SECURITY NO. 578-03-6484		17. INFORMANT Rudolph W. Ficken 711 Dale Drive Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Skull and cerebral metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Mammary carcinoma left breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. <u>174X</u> <u>11 1/2 years</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>170X</u>															
19a. DATE OF OPERATION May 15 '57		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Mammary carcinoma				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) No Injury											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) No Injury		21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 1</u> , 19 <u>57</u> , to <u>OCTOBER 14</u> , 19 <u>68</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>OCTOBER 14</u> , 19 <u>68</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death.															
22b. SIGNATURE <u>Charles F. Geschickter</u>				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Oct 14 1968			
22d. PHYSICIAN'S NAME (Type) Charles F. Geschickter, M.D.				22e. ADDRESS 1834 Conn. Ave., N.W. Washington, DC											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-17-1968		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d. LOCATION (City or Town) (County) (State) Rockville Montgom. Md.							
24. GENERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S. Md.				25a. REC'D BY REGISTRAR DATE OCT 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <i>Waxman E.</i>			First <i>Fincham</i>		Middle <i>Fincham</i>		Last <i>Fincham</i>		2a. DATE OF DEATH <i>Oct</i> Month <i>5</i> Day Year <i>1968</i>		2b. HOUR <i>11</i> M	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>6-16-1887</i>			6. AGE (In years last birthday) <i>81</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md.					
10. CITY OR TOWN OF DEATH <i>Olney</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address.) <i>Brookgrove Road Brooke Grove Foundation</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Master Mechanic</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Gov't.</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Sil. Spr.</i>		13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>8614 2nd Avenue</i>			
14. FATHER'S NAME First <i>George</i> Middle <i>Clinton</i> Last <i>Fincham</i>				15. MOTHER'S MAIDEN NAME First <i>Weakley</i> Middle <i>Vianna</i> Last <i>Vianna</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <i>215-462-469</i>		17. INFORMANT Address <i>Kensington, Md.</i> <i>Mr. Alvin F. Fincham 3409 Farragut Street</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Large Bowel obstruction &amp; Perforation</i> <i>1549</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of Rectum</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>2 years</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>154 X</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (the hospital) attended the deceased from <i>May 18</i> , 19 <i>65</i> , to <i>Oct 2</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Oct 2</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Gene U. Cohen</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>Oct 9, 1968</i>				
22d. PHYSICIAN'S NAME (Type) <i>Gene U. Cohen</i>						22e. ADDRESS <i>1106 Spring St., Silver Spring, Md.</i>						
23a. BURIAL, CREMATION, BENEFIT (Specify)		23b. DATE <i>10-11-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Prince Georges, Maryland</i>					
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>						ADDRESS <i>Sil. Spr. Md.</i>		25a. REC'D BY REGISTRAR <i>OCT 11 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



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14610

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Hester FLORENCE Finkenbinder</b>			2a. DATE OF DEATH <b>10</b> Month <b>14</b> Day <b>68</b> Year		2b. HOUR <b>8:45</b> M
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>12/20/1895</b>		6. AGE (In years last birthday) <b>72</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery Co.</b> Md.	
10. CITY OR TOWN OF DEATH <b>Kensington</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Kensington Gardens Sanitarium</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retail Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Mont.</b>	13c. CITY OR TOWN <b>Wheaton</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET AND NUMBER <b>11942 Bluehill Rd.</b>	
14. FATHER'S NAME First Middle Last <b>Samuel Schwarber</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Margaret Rowe</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>577-05-9641</b>		17. INFORMANT Address <b>WHEATON MD 11942 BLUEHILL RD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Attack</b> <b>4369</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>None</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>331X</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>
19a. DATE OF OPERATION <b>20</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 19, 1968</b> to <b>Oct 14, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 12, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John S. Rogers</b>		22c. DATE SIGNED <b>Oct 14, 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>JOHN S. ROGERS</b>	
22e. ADDRESS <b>KENSINGTON, MD</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			
23b. DATE <b>10/17/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CHAPEL</b>		23d. LOCATION (City or Town) (County) (State) <b>LIBERTY TOWN MD</b>	
24. FUNERAL DIRECTOR <b>D.D. Hartzler &amp; Sons Union Bridge</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

14611

14619

1. DECEASED-NAME (Type or print) <b>Kent Sheridan Foster</b>			2a. DATE OF DEATH Month <b>October</b> Day <b>22</b> Year <b>1968</b>			2b. HOUR <b>5:00</b> AM			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>22 June 1957</b>		6. AGE (In years last birthday) <b>11</b> YRS.		IF UNDER 1 YEAR MONTHS <b>11</b> DAYS <b>11</b> HOURS <b>11</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>California</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center, NIH</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Nevada</b>		13b. CITY <b>Clark</b>		13c. CITY OR TOWN <b>Las Vegas</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>300 Fuchia Circle</b>	
14. FATHER'S NAME First <b>Robert</b> Middle <b>E.</b> Last <b>Foster</b>			15. MOTHER'S MAIDEN NAME First <b>Janice</b> Middle <b>Hamler</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Bethesda, Maryland 20014</b> <b>The Medical Records, The Clinical Center</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>448X</b> IMMEDIATE CAUSE (a) <b>Acute Bronchitis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchiectasis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ataxia Telangiectasia</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 Days</b> <b>Years</b> <b>Years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <b>467.1</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>18 Sept.</b> , 19 <b>68</b> , to <b>22 Oct.</b> , 19 <b>68</b> , that <del>he</del> (we) last saw the deceased alive on <b>22 October</b> , 19 <b>68</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>did not</del> view the body after death.									
22b. SIGNATURE <b>Dale E. McFarlin</b>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/22/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dale E. McFarlin, M. D.</b>						22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-26-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Las Vegas, Nevada</b>			
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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10-20-68

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14620

14612

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>MARY ELIZABETH FRANCIS</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>14</b> Year <b>68</b>			2b. HOUR <b>8:55 A.M.</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>W.</b>		5. DATE OF BIRTH <b>2-24-86</b>		6. AGE (In years last birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS <b>8</b> DAYS <b>8</b> HOURS <b>8</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>PENN.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.			
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASH. SAN. Y. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>NONE</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>MONTG.</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>11312 Clowhill Dr.</b>	
14. FATHER'S NAME First <b>CHARLES</b> Middle <b>GRIM</b> Last <b>GRIM</b>			15. MOTHER'S MAIDEN NAME First <b>ANNA</b> Middle <b>?</b> Last <b>?</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		(If yes give year or dates of service) <b>***</b>		16b. SOCIAL SECURITY NO. <b>Not Avail.</b>		17. INFORMANT <b>Washington Sanitarium &amp; Hospital, Takoma Park, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b> <b>2509</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>2607</b> (b) <b>Hypoglycemic Reaction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>Arteriosclerotic Cardiovascular Disease</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 3, 1968</b> , to <b>Oct 14, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct. 14, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.									
22b. SIGNATURE <b>Raymond Bradshaw, MD</b>				DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Oct 14, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>RAYMOND BRADSHAW, M.D.</b>				22e. ADDRESS <b>Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10/15/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westminster Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Philadelphia, Penna.</b>			
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY,</b>				ADDRESS <b>7557 Wisconsin Ave Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>OCT 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

14613		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14621	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH	
NORMAN D FRANCIS						Month	Day
						10	26
3. SEX			4. RACE		5. DATE OF BIRTH	6. AGE (In years last birthday)	
MALE			WHITE		JUNE 1-1908	60 YRS.	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
BESSEMER (NC) U.S.A.			U.S.A.		9. COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
SILVER SPRINGS			Bella Vista Nursing Home		Retail Salesman		Clothing
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
D.C.			WASH		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1410-M St. N.W.
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME	
NOAH D. FRANKS						CONDREY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		
Yes, no, or unknown			Geo (World W. 2) 250-03-9017		Helen S. Huer 516 Oak Dale Avenue		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Cerebral Hemorrhage							1 Day
DUE TO, OR AS A CONSEQUENCE OF							
(b) Arteriosclerotic Heart Disease							5 Yrs
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
4200							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
					YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
		HOUR A.M. Month Day Year					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION			
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Aug. 1968, to Oct-26-1968, that (I) (we) last saw the deceased alive on 10/31/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Harold Heeger MD						10/26/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
Herold Heeger MD				5415 Conn. Ave NW DC			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		10-31-1968		Sunset Cemetery		Shelby North Carolina	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
C. E. Wisor				DATE		OCT 30 1968	
Warner E. Pumphrey, Inc. 8434 Ga. Avenue						J Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14614

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14622

1. DECEASED-NAME (Type or print) First Middle Last James Archie Furgason			2a. DATE OF DEATH Month Day Year 10-30-1968		2b. HOUR 7:26PM
3. SEX Male	4. RACE W	5. DATE OF BIRTH 10-1-95		6. AGE (In years last birthday) 72 1/3 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Oneonta, N.Y.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.	
10. CITY OR TOWN OF DEATH Takoma Park, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington San. & Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Tk. Park	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 7346 Carroll Ave.	
14. FATHER'S NAME First Middle Last Curtis Stewart Furgason			15. MOTHER'S MAIDEN NAME First Middle Last Cynthia Kathryn Bedine		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 297-01-8809		17. INFORMANT Address Margaret E. Furgason 7346 Carroll Avenue Tak. Pk. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4321</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Chronic Abdominal Aorta</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>Oct 30, 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug 26, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Richard L. Whelton</u> M.D. DEGREE				22c. DATE SIGNED <u>Oct 30, 1968</u>	
22d. PHYSICIAN'S NAME (Type) Richard L. Whelton, M.D.				22e. ADDRESS 1017 University Blvd. East, S.S. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 11-2-1968	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville Montgomery Md.	
24. FUNERAL DIRECTOR <u>Warner E. Purphrey, Inc.</u> 8434 Ga. Avenue				25a. REC'D BY REGISTRAR DATE NOV 7 1968	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

16014

14835

RECEIVED IN DEATH

NOV 1 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

14615				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14623					
1. DECEASED-NAME (Type or print)				First Middle Last				2a. DATE OF DEATH Month Day Year				2b. HOUR	
Eula Blanche Gardner								October 13, 1968				2:35 PM	
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Female		White		January 7, 1880				88 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						Md	
TENN.		America				Montgomery							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
Takoma Park				Washington Sanitarium				HOUSEWIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. CITY OR TOWN				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Washington D.C.				D.C.				N.W.		2039 New Hampshire ave			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last									
ALLEN TATE				ARIANNA PECK									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.				17. INFORMANT				Address	
no				UNKNOWN				Patient's chart				8602 SUNDALE DR SIL. SPC. MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonia 492X DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 5271 (c) Pulmonary Emphysema 3 days												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Recent Cerebral Vascular Accident, Atrial fibrillation, Chronic Bicuspid Syndrome													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10-10, 1968, to 10-13, 1968, that (I) (we) last saw the deceased alive on 10/13/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Alan R. Gair				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE, SIGNED 10/13/68					
22d. PHYSICIAN'S NAME (Type) ALAN R. GAIR M.D.				22e. ADDRESS 3118 Craiglawn Rd, Bethesda, Md									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)	
Burial				10-15-68				GLENWOOD CEM.				WINCOLN RD. N.E. WASH, D.C.	
24. FUNERAL DIRECTOR W.C. CHAMBERS 1400 CHAPIN ST. N.W. WASH DC				ADDRESS				25a. REC'D BY REGISTRAR DATE OCT 15 1968				25b. REGISTRAR'S SIGNATURE Charles Judge	



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Case closed with medical examiner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

14616				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14624			
1. DECEASED-NAME (Type or print) First Middle Last				2a. DATE OF DEATH Month Day Year				2b. HOUR 30 45 00			
3. SEX male		4. RACE white		5. DATE OF BIRTH Nov. 8, 1910		6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Englewood		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Engineer					
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 912-Twinbrook Place			
14. FATHER'S NAME First Middle Last Thomas F. Carey III		15. MOTHER'S MAIDEN NAME First Middle Last Edith Estelle Cole									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war and dates of service) yes World War II 1946-1946 38		16b. SOCIAL SECURITY NO. 42-38638		17. INFORMANT Address Lucille Helen Carey Same Bethesda							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Coronary arteriosclerosis 10 years.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH none	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from June 1938, to Oct. 5, 1968, that (I) (we) last saw the deceased alive on Aug. 25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Samuel T. Kimble MD				DEGREE MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10-5-68	
22d. PHYSICIAN'S NAME (Type) SERUCH T. KIMBLE				22e. ADDRESS 9801 Georgia Ave. Silver Spring Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-9-68		23c. NAME OF CEMETERY OR CREMATORY Baltimore Natl Cem.		23d. LOCATION (City or Town) Baltimore, Maryland		(County)		(State)	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland				ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

28841

21041

RECEIVED IN BULK



10-2-58

RECEIVED IN BULK

RECEIVED IN BULK 10-2-58

RECEIVED IN BULK 10-2-58

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4-10-64  
30M REV 11-68

14617		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		14625	
Item 16b Film 405		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) First Middle Last George Washington Garland			2a. DATE OF DEATH Month Day Year 10 6 68		2b. HOUR 10:50 AM
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 29 1892	
6. AGE (In years last birthday) 76 YRS.		7. COUNTY OF DEATH Montgomery		8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Washington DC.		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3650 Gleneagles Dr.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cartographic Eng.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
14. FATHER'S NAME Jefferson D. Garland		15. MOTHER'S MAIDEN NAME Margaret Hemphill		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	
16b. SOCIAL SECURITY NO. 134-1401678A		16c. INFORMANT Mrs Louise Garland		16d. ADDRESS 3650 Gleneagles Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, severe. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 332X					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days. years.
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Nov. 19 66, to Oct. 6 1968, that (I) (we) lost saw the deceased alive on 10/6/68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard A. Yates, M.D.		22c. DATE SIGNED 10/7/68		22d. PHYSICIAN'S NAME (Type) Richard A. Yates, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-10-1968		23c. NAME OF CEMETERY OR CREMATORY Edgar Hill Cemetery	
23d. LOCATION (City or Town) (County) (State) Prince Georges, Md.		23e. REC'D BY REGISTRAR OCT 8 1968		23f. REGISTRAR'S SIGNATURE J. Charles Judge	
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Georgia Avenue					

10-10-1982

OCT 8 1982

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14618

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14626

1. DECEASED-NAME (Type or Print) <i>Anna</i> First <i>V.</i> Middle <i>U.</i> Last <i>Heister</i>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>Oct</i> Day <i>2</i> Year <i>1968</i>			2b. HOUR <i>7:10 PM</i>		
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>5/18/13</i>	6. AGE (In years last birthday) <i>55</i> YRS.	IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>	IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>	2c. DATE PRONOUNCED DEAD Month <i>Oct</i> Day <i>2</i> Year <i>1968</i>		
7a. BIRTHPLACE (State or foreign country) <i>Denna</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>4506 Cheltenham Dr.</i>
14. FATHER'S NAME First <i>Joseph</i> Middle <i></i> Last <i>Grindle</i>			15. MOTHER'S MAIDEN NAME First <i>Wilhelmenia</i> Middle <i></i> Last <i></i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Husband</i>		ADDRESS <i>Same as above</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Decubitus Ulcers of hips infected</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Fracture of Right Hip</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>2 months</i> <i>5 months</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>904.0 Multiple Sclerosis</i>								
19a. DATE OF OPERATION <i>May 7, 1968</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Nothing of Fracture of Rt hip</i>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <i>5 P.M. May 4 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Fell at home causing fracture of Rt hip</i>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. <i>4506 Cheltenham Dr.</i> City or Town <i>Bethesda</i> County <i>Mont.</i> State <i>Md.</i>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John E. Ball</i>		EXAMINER'S NAME (Type) <i>JOHN E. BALL</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>Oct. 3, 1968</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>10-5-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Silver Spring, Md.</i>		
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR <i>OCT 7 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



14038

14038

REPORT OF THE MEDICAL EXAMINER'S OFFICE  
OF THE DISTRICT OF COLUMBIA  
IN CONNECTION WITH THE  
CASE OF

At the residence of  
the deceased

No. 1

Deceased, age

John O. Smith

10-5-28

Date of Death

10-5-28

10-5-28

Deceased, age

Robert A. Pomeroy



CERTIFICATE OF DEATH

14627

14619

1. DECEASED-NAME (Type or print) First Middle Last <b>Cecil Lamont Gingerich</b>			2a. DATE OF DEATH Month Day Year <b>October 16 1968</b>		2b. HOUR <b>11:59</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>21 June 1921</b>		6. AGE (In years last birthday) <b>47</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Iowa</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH <b>Montgomery</b> Md.		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center, NIH</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Investments</b>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Florida</b>	13b. COUNTY <b>Sarasota</b>	13c. CITY OR TOWN <b>Sarasota</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET AND NUMBER <b>7606 Peninsula Drive</b>	
14. FATHER'S NAME First Middle Last <b>Arthur C. Gingerich</b>	15. MOTHER'S MAIDEN NAME First Middle Last <b>Vina Yoder</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16b. SOCIAL SECURITY NO. <b>1944-1946</b>	17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, NIH, Bethesda, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis - Shock</b> <b>2050</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia, Bilateral</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Myelogenous Leukemia</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b> <b>10 Days</b> <b>1 Year</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>2043</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9 September, 1968</b> , to <b>16 Oct., 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>16 October 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Brian W. Goodell M.D.</b>	DEGREE <b>M.D.</b>	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>10/17/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Brian W. Goodell, M. D.</b>	22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-19-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sarasota Mem. Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Sarasota, Florida</b>		
24. FUNERAL DIRECTOR <b>Everly-Wheatley Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Oct 23 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14620

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14628

1. DECEASED-NAME (Type or Print) <b>NATHANIEL</b>			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>OCT 15 1968</b>			2b. HOUR <b>12 PM</b>				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>5/4/1885</b>		6. AGE (In years last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>N.Y.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>MONTGOMERY</b>				
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SUBURBAN</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>				13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>CHERRY CHASE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>8802 WALNUT HILL ROAD</b>			
14. FATHER'S NAME First Middle Last <b>ABRAHAM GLASSER</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>REBECCA</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>577-07-1343</b>				
16c. INFORMANT <b>MRS SIDNEY SCHUMAN - Daughter</b>			ADDRESS <b>SAME AS.</b>			17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>411.9 Coronary Insufficiency Acute -</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Arterio Sclerosis Generalized -</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>years.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days.</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201 Fracture of Rt. Hip.</b>													
19a. DATE OF OPERATION <b>10/9/68</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Repair of fracture of Rt. Hip.</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year <b>OCT 4 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Fall in bath room.</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Nursing Home</b>				21f. LOCATION Street or R.F.D. No. City or Town County State <b>Kensington Nursing Home Kensington Mont. Md.</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>John G. Ball</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>OCT. 15, 1968.</b>					
EXAMINER'S NAME (Type) <b>JOHN G-BALL</b>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
ADDRESS (Street, city, town, or county)				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE <b>10-17-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ADAS ISRAEL CEMETERY WASHINGTON DC</b>			
24. FUNERAL DIRECTOR <b>BERNARD DANZANSKY &amp; SONS - WASHINGTON DC</b>				ADDRESS				25a. REC'D BY REGISTRAR <b>OCT 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

25341

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 days after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <b>GRACE M. GIERUM</b>						2a. DATE OF DEATH Month <b>10</b> Day <b>24</b> Year <b>1968</b>			2b. HOUR <b>2:30</b> P.M.			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Feb 3 1888</b>			6. AGE (In years last birthday) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS <b>80</b> DAYS <b>0</b> HOURS <b>0</b> MIN.		IF UNDER 24 HRS. HOURS <b>0</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>ILLINOIS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.						
10. CITY OR TOWN OF DEATH <b>Kensington</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Kensington Gardens Sanit</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>House wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3213 Verona Place</b>		
14. FATHER'S NAME First <b>Costar</b> Middle <b>Bergman</b> Last <b>Bergman</b>				15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Olsen</b> Last <b>Olsen</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>578-30 8805</b>		17. INFORMANT <b>Son</b> Address <b>Mr. Jay Gierum 3213 Verona Pl. Wheaton, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>												
4129 DUE TO, OR AS A CONSEQUENCE OF (b) _____												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4200</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____								
22a. I certify that (I) (this hospital) attended the deceased from <b>1963</b> , 19____, to <b>Oct. 24, 1968</b> , that (I) (we) last saw the deceased alive on <b>9/26/68</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>A. W. Smith M.D.</b> DEGREE <b>MD.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>10/24/68</b>						
22d. PHYSICIAN'S NAME (Type) <b>A. W. SMITH</b>						22e. ADDRESS <b>13018 GEORGIA AVE WHEATON, MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 26, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Ridge Cemetery</b>				23d. LOCATION (City or Town) <b>Kenosha,</b> (County) <b>Wisconsin</b> (State) <b>Wisconsin</b>				
24. FUNERAL DIRECTOR <b>C. Glen Carter</b>						25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				
Warner E. Humphrey, Inc., 8434 Ga., Ave., Md.						DATE <b>OCT 28 1968</b>						



1963

1963

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

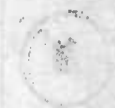
CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH



HT 1052 V.A.

OCT 19 1963



14622

14630

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Alma</b>			First Middle Last <b>M. GOODE</b>			2a. DATE OF DEATH Month Day Year <b>October 9 68</b>			2b. HOUR <b>630p M</b>					
3. SEX <b>Female</b>			4. RACE <b>Negro</b>			5. DATE OF BIRTH <b>June 18, 1915</b>			6. AGE (In years last birthday) <b>53</b> YRS.					
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b> Md.					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>District of Columbia</b>			13b. COUNTY <b>Washington</b>			13c. CITY OR TOWN <b>Washington</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>1501 Crittenden St., N.W.</b>		
14. FATHER'S NAME First Middle Last <b>Adolphus Wiggins</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Lillian Drake</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or (unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Washington D. C.</b> <b>Benjamin C. Coode, 2116 F St., N.W. Apt. 108</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TRANSINNAL CELL CARCINOMA OF BLADDER WITH WIDE</b> <b>188 X</b> DUE TO, OR AS A CONSEQUENCE OF <b>SPREAD METASTASIS.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1810</b>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 9, 1968</b> , to <b>Oct. 9, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Oct. 9, 1968</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>Donald J. Jarzynski</b> DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>Oct. 10, 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>DONALD J. JARZYNSKI</b>						22e. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>Oct-14-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Church Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>					
24. FUNERAL DIRECTOR <b>Spangler Funeral Home</b>						25a. REC'D BY REGISTRAR <b>Charles Judge</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					
524 8th St., N.E., Washington, D. C.														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

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and information: <http://www.elsevier.com/locate/locate/locate>

Fig. 1.  $\Delta T$  vs.  $\Delta T_{\text{max}}$  for different values of  $\Delta T_{\text{max}}$  and  $\Delta T_{\text{min}}$ .

DATE: 11/11/1964

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DONALD L. BARRETT

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Journal of Management Inquiry 22(4)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14623		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14631			
1. DECEASED-NAME (Type or print) First Middle Last <b>MIRIAM MORGAN GORDON</b>						2a. DATE OF DEATH Month Day Year <b>October 24, 1968</b>		2b. HOUR P <b>2:45 M</b>	
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>June 18, 1878</b>		6. AGE (In years last birthday) <b>90</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Kensington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>10106 Thornwood Road</b>	
14. FATHER'S NAME First Middle Last <b>JOHN MORGAN</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY FRANCES BOLAND</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No ****</b>					
16b. SOCIAL SECURITY NO. <b>578-09-8746</b>		17. INFORMANT <b>10106 Thornwood Road, Mrs. Miriam G. Griest, Kensington, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4500 Generalized osteoporosis</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 1968</b> , to <b>24 Oct 1968</b> , that (I) (we) last saw the deceased alive on <b>24 Oct 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Herbert Martyn, Jr. MD</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>25 Oct 68</b>	
22d. PHYSICIAN'S NAME (Type) <b>HERBERT MARTYN, JR., MD</b>		22e. ADDRESS <b>4740 Chevy Chase Drive Chevy Chase, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		23b. DATE <b>10/28/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Mausoleum</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Pr. Geo. Maryland</b>			
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland.</b>		ADDRESS <b>7557 Wisconsin Ave.</b>		25a. REC'D BY REGISTRAR <b>NOV 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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Northampton

10108 Northampton Road

JOHN

275-02-2702 Mrs. William J. Kennedy

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14624

CERTIFICATE OF DEATH

14632

1. DECEASED-NAME (Type or print) <b>ETHEL D. GRANT</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>25</b> Year <b>68</b>			2b. HOUR <b>7A</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>2-23-88</b>		6. AGE (In years last birthday) <b>80</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.	
1d. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOME MAINTENANCE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>CHEVY CHASE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>6620 HILLDALE RD.</b>		14. FATHER'S NAME First Middle Last <b>Joseph Wm. Dowman</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Dell Spence</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-266877</b>		17. INFORMANT (son) <b>BEN. J. GRANT - 7000 ORENCY PKWY MD.</b>		Address <b>Bethesda</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic &amp; cardiac failure</b> <b>1533</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of sigmoid</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>1 yr.</b> <b>unknown</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1533</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>58</b> , to <b>Oct</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>24 Oct</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Herbert Martyn MD</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>25 Oct 68</b>	
22d. PHYSICIAN'S NAME (Type) <b>HERBERT MARTYN JR</b>				22e. ADDRESS <b>4740 Chevy Chase Dr.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10-26-1968</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) <b>Dothan, Alabama</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION



14653

THE HOUSE OF COMMONS

14653

*[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like "The House of Commons" and "14653" are visible.]*



14625

## CERTIFICATE OF DEATH

14633

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. DECEASED-NAME (Type or print) <b>Betty</b> First <b>ANN</b> Middle <b>Greenwood</b> Last			2a. DATE OF DEATH Month <b>Oct</b> Day <b>17</b> Year <b>68</b>			2b. HOUR <b>8:15</b> AM	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>5/1/26</b>		6. AGE (In years last birthday) <b>42</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>WASHINGTON, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b>	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>SUBURBAN</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSE WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <b>THEODORE</b> First <b>VOLLTEN</b> Middle <b>IDA</b> Last		15. MOTHER'S MAIDEN NAME <b>BEAN</b> First <b>IDA</b> Middle <b>BEAN</b> Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>219-22-4586</b>		17. INFORMANT <b>AUSTIN GREENWOOD - HUSBAND - SAME</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4300</b> IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ruptured aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>330x Hypertension (one year duration)</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1966</b> , <b>1968</b> to <b>17 Oct</b> , <b>1968</b> , that (I) (we) last saw the deceased alive on <b>16 Oct</b> , <b>1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>Paul T. Noone MD</b>		22c. DATE SIGNED <b>12 Oct 68</b>					
22d. PHYSICIAN'S NAME (Type) <b>PAUL T. NOONE</b>		22e. ADDRESS <b>5201 Randolph Road Rockville, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-21-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>OCT 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

1983

1983

UNITED STATES OF AMERICA

AM

210-20-1000

2201 Randolph Road  
Rockville, Maryland

UNITED STATES OF AMERICA

10-21-88

Oct 22 1988

Rockville, Maryland

UNITED STATES OF AMERICA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14626					14634				
1. DECEASED-NAME (Type or print) First Middle Last					2a. DATE OF DEATH Month Day Year			2b. HOUR	
James H. Gulli					Oct. 25, 1968			5:30 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
male		white		11/10/20		47 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
Washington		U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban Contractor		Building					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md. Prince Georges County								6515 8th Ave.	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last							
Joseph B. Gulli		Bertrude Noland							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
yes		1579-12-236		Marguerite Gulli		As above.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Acute myocardial Infarction								2 hours	
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease								4 years	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 1955, 19, to 10/25, 1968, that (I) (we) last saw the deceased alive on Oct 8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thomas E. Curtin M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/25/68		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS 1150 Varnum St N.E. Wash D.C. (Residence)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10/28/68		Gate of Heaven Cem.		Silver Spring, Md.			
24. FUNERAL DIRECTOR Valley's Funeral Home					24a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Home Dr.					OCT 31 1968		Charles Judge		

14084

RECEIVED

14084

800 1 6 100

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14627

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14635

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		2b. HOUR	
ALEXINA K. GUSEK					Month Day Year Oct. 24, 1968		UNK M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
female	white	June 4, 1911		57 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR
Pennsylvania		U.S.A.				Montgomery		2c. DATE PRONOUNCED DEAD Month Day Year October 27, 1968
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda		4743 Bradley Boulevard		Homemaker		Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Maryland		Montgomery		Bethesda		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4743 Bradley Blvd. Apt. 307
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
James					Helen			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		17. ADDRESS		
No		Not Avail.		Brother; James D. Keay, Jr.		Russell, Mass.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatty Alteration of Liver</u> 571.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 5810								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b. DATE SIGNED				
Werner U. Spitz, M.D.				10/28/68				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Removal		10/29/68		Pine Hill Cemetery		Westfield, Hampden, Mass.		
24. FUNERAL DIRECTOR		7557 Wisconsin Ave. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY, Bethesda, Maryland				DATE NOV 4 1968		J. Charles Judge		



14034

14034

FOR STATE  
HEALTH DEPT.



Name: <u>James E. Kelly</u>		Date: <u>4-1-37</u>	
Address: <u>1111 1st St.</u>		City: <u>St. Louis</u>	
State: <u>Mo.</u>		County: <u>St. Louis</u>	
Occupation: <u>None</u>		Age: <u>35</u>	
Sex: <u>Male</u>		Race: <u>White</u>	
Religion: <u>Catholic</u>		Marital Status: <u>Single</u>	
Education: <u>High School</u>		Previous Illnesses: <u>None</u>	
Current Illness: <u>None</u>		Treatment: <u>None</u>	
Physician: <u>None</u>		Hospital: <u>None</u>	
Referral: <u>None</u>		Remarks: <u>None</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*See Cleared with Medical Examiner John B. Bell, Jr. - October 1968*

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) <b>MYRON E. GUSTAFSON</b>		2a. DATE OF DEATH Month <b>OCTOBER</b> Day <b>12</b> Year <b>1968</b>		2b. HOUR <b>11 58 P.M.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>June 23, 1910</b>	6. AGE (In years last birthday) <b>58</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Nebraska</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Montgomery</b> Md.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross Hospital</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Manager-outburner serv.</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Ref</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Sil. Spr.</b>	13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET AND NUMBER <b>701 McNeil Road</b>
14. FATHER'S NAME First <b>Theodore M.</b> Middle <b>Gustafson</b> Last <b>Gustafson</b>	15. MOTHER'S MAIDEN NAME First <b>Nancy</b> Middle <b>(Unknown)</b> Last <b>(Unknown)</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW II</b>	16b. SOCIAL SECURITY NO. <b>577-10-0062</b>	17. INFORMANT Address <b>Avis Gustafson 701 McNeil Road Sil. Spr. Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock * pulmonary edema</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary artery disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>12 hrs.</b> <b>10 yrs.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (1) (this hospital) attended the deceased from <b>Aug</b> , 19 <b>60</b> , to <b>Oct 12</b> , 19 <b>68</b> , that (1) (we) lost saw the deceased alive on <b>10/12</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above (1) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>James R. Coleman MD</b>	DEGREE <b>MD</b>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>10/12/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>JAMES R. COLEMAN</b>	22e. ADDRESS <b>9241 COLUMBIA BLVD. SILVER SPRING, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-16-1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Rockville Montgomery Md.</b>	
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</b>		25a. REC'D BY REGISTRAR <b>OCT 21 1968</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

10038

10038

10038



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1055 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 407  
12-23-68 am DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14629

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14637

1. DECEASED-NAME (Type or Print) <i>James Harrington Hagen</i>			First <i>JAMES</i> Middle <i>HARRINGTON</i> Last <i>HAGEN</i>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> <i>Oct 11</i> 1968			2b. HOUR <i>2:28</i> M			
3. SEX <i>M.</i>		4. RACE <i>W.</i>		5. DATE OF BIRTH <i>Feb 18, 1945</i>		6. AGE (In years lost birthday) <i>23</i> YRS.		7. DATE PRONOUNCED DEAD Month <i>Oct</i> Day <i>11</i> Year <i>1968</i>		2d. HOUR <i>7:20</i> M		
7a. BIRTHPLACE (State or foreign country) <i>Washington DC</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Montgomery</i> Md.			
10. CITY OR TOWN OF DEATH <i>Bethesda</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>5215 Belvoir Dr</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>				13b. COUNTY <i>Montgomery Bethesda</i>		13c. CITY OR TOWN <i>Bethesda</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>5215 Belvoir Dr</i>		
14. FATHER'S NAME First <i>Stanley</i> Middle <i>Hagen</i> Last <i>Paulsen</i>				15. MOTHER'S MAIDEN NAME First <i>Paulsen</i> Middle <i>Miller</i> Last <i>Miller</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>				16b. SOCIAL SECURITY NO. <i>N-12-6470 12-17-66</i>		17. INFORMANT ADDRESS <i>MRS. PAULEEN M. HAGEN, MOTHER, SAME AS #13</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PHYSICAL</i> <i>Anoxia</i> <i>8569</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Overdose of narcotics</i> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>874.0</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>		
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <i>2 ? P.M. Oct 11 19 68</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Injected narcotics by vein self inflicted</i>								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. <i>5215 Belvoir Dr.</i>		City or Town <i>Bethesda</i>		County <i>Montg.</i>		State <i>Md.</i>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>John S. Ball</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>Oct 12, 1968</i>				
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal-Burial</i>		23b. DATE <i>10-17-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Massanutten Cemetery</i>		23d. LOCATION (City or Town) <i>Woodstock, Virginia</i>		(County)		(State)		
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</i>						25a. REC'D BY REGISTRAR <i>OCT 21 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

14837

14837

STATE OF TEXAS, COUNTY OF DALLAS

IN THE DISTRICT COURT OF THE

STATE OF TEXAS

IN RE: THE ESTATE OF

JOHN W. BROWN, DECEASED

VS. THE STATE OF TEXAS

AND THE COUNTY OF DALLAS

VS. THE DISTRICT COURT OF THE

STATE OF TEXAS

VS. THE COUNTY OF DALLAS

VS. THE STATE OF TEXAS

VS. THE COUNTY OF DALLAS

VS. THE STATE OF TEXAS

VS. THE COUNTY OF DALLAS

VS. THE STATE OF TEXAS

VS. THE COUNTY OF DALLAS

VS. THE STATE OF TEXAS

VS. THE COUNTY OF DALLAS

VS. THE STATE OF TEXAS

14630

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>MISS Ellen E. Hall</i>			2a. DATE OF DEATH Month <i>10</i> Day <i>30</i> Year <i>68</i>			2b. HOUR <i>1:28</i> M		
3. SEX <i>Female</i>		4. RACE <i>W. White</i>		5. DATE OF BIRTH <i>10-31-1887</i>		6. AGE (In years last birthday) <i>78</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>PA.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Montgomery</i> Md.		
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Holy Cross Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Clerk</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Sil. Spr.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <i>Thomas J.</i> Middle <i>J.</i> Last <i>Hall</i>			15. MOTHER'S MAIDEN NAME First <i>Catherine M. J.</i> Middle <i>M. J.</i> Last <i>Lally</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>137-18-1686</i>		17. INFORMANT Address <i>Catherine Hall 804 Arrington Dr. S.S., Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>with Congestive Heart Failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4221</i> <i>Broncho pneumonia</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>Oct 26, 1968</i> , to <i>Oct 30, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 29, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Bernard A. Fitzgerald</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>10-30-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>BERNARD A. FITZGERALD</i>				22e. ADDRESS <i>217 UNIV. BLVD. SILVER SPRING MD</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>11-2-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Vineland, New Jersey</i>		
24. FUNERAL DIRECTOR <i>Warner E. Purphrey, Inc. 8434 Georgia Ave.</i>				25a. REC'D BY REGISTRAR <i>NOV 4 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14838

RECEIVED

14838





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14631

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14639

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>ADA GAY HARMON</b>			2a. DATE OF DEATH Month Day Year <b>October 22, 1968</b>			2b. HOUR A <b>1:00 M</b>			
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>Feb. 7, 1879</b>		6. AGE (In years last birthday) <b>89</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>4523 Avondale Street</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4523 Avondale Street</b>	
14. FATHER'S NAME First Middle Last <b>Arthur Webster Paxton</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Augusta Rogers Snively</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown		16b. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Daughter Lois H. Boatwright Same as Item 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>5609</b> IMMEDIATE CAUSE (a) <b>INTESTINAL OBSTRUCTION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>5705G GENERALIZED ARTERIO SCLEROSIS</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>June, 1968</b> to <b>Oct 21, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 21, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Leo I. Donovan</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10-22-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>LEO I. DONOVAN</b>				22e. ADDRESS <b>8218 Wisconsin Ave. Bethesda, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-25-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Nebo, Virginia</b>			
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			

14833

14833

FURNITURE OF CHAIR

October 22, 1968 1:00

HARRISON

GAY

AND

29

1972

Feb. 7, 1972

Gore.

female

MONTGOMERY

MONTGOMERY

U. S. A.

MONTGOMERY

MONTGOMERY

MONTGOMERY

4525

MONTGOMERY

4525 Avenue Street

MONTGOMERY

MONTGOMERY

MONTGOMERY

Augusta Rogers Smith

Augusta Rogers Smith

Smith as listed in

Smith as listed in

Unknown

No

DOWN

10-22-68

Bela Wisconsin Ave.  
Richmond, Maryland

AND J. ROYAN

Richmond, Virginia

10-22-68 Richmond, Virginia

10-22-68

ROBERT A. HUNTER, Richmond, Virginia

OCT 21 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14638

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14640

1. DECEASED-NAME (Type or print) Leonard Boyd Harper			2a. DATE OF DEATH Month Day Year October 31 1968			2b. HOUR 9:50 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH August 5, 1936		6. AGE (in years last birthday) 32 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) The Clinical Center, NIH		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesclerk		12b. KIND OF BUSINESS OR INDUSTRY Fuel & Feed			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince Georges		13c. CITY OR TOWN College Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9729 Wichita Ave	
14. FATHER'S NAME Leonard W. Harper		15. MOTHER'S MAIDEN NAME Dellie I. Bennett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-34-8740		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1929 Intracerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Increased Intracranial pressure DUE TO, OR AS A CONSEQUENCE OF (c) Glioblastoma Multiforme								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days days 6 Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 1939									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from October 29, 1968, to October 31, 1968, that (X) (we) last saw the deceased alive on October 31, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Fremont P. Wirth, Jr., MD.		22c. DATE SIGNED 10/31/68		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Nov 2, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo, Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE NOV 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14633

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14641

1. DECEASED-NAME (Type or Print) <i>Helen Virginia Harris</i>		2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <i>Oct 3</i> Year <i>1968</i>		2b. HOUR <i>3:30</i> -M
3. SEX <i>Fe</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>9/10/1905</i>	6. AGE (In years last birthday) <i>63</i> YRS.	7c. DATE PRONOUNCED DEAD <i>Oct</i> Month <i>3</i> Day Year <i>1968</i>
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Montgomery</i> Md.
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Montgomery</i>		13b. COUNTY <i>Rockville</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First <i>Robert E.</i> Middle <i>Lee</i> Last <i>O'Neale</i>		15. MOTHER'S MAIDEN NAME First <i>Margaret</i> Middle <i>Collins</i> Last <i></i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Brother</i> <i>Wm. M. O'Neale</i> <i>6001 Wilmett Rd. Bethesda, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anoxia</i> <i>890X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Carbon Monoxide + Smoke Inhalation - 1/2 hr.</i> (b) <i>House fire</i> (c) <i>House fire</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hr.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>9160</i>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <i>3 PM 10/3 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Sofa caught on fire from cigarette</i>
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Home</i>		21f. LOCATION Street or R.F.D. No. <i>9500 Eldwick Way</i> City or Town <i>Rockville</i> County <i>Montgomery</i> State <i>Md</i>
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John G. Ball</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <i>JOHN G. BALL</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ADDRESS (Street, city, town, or county) <i>Bethesda, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>10-7-68</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Potomac Meth.Ch.Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Potomac, Maryland</i>
24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>OCT 9 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



1990



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14634										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14642																													
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																													
First MARY Middle Duffu Last HART										Month 10 Day 30 Year 68										9 1/4 M																													
3. SEX FEMALE										4. RACE WHITE										5. DATE OF BIRTH 10-9-16										6. AGE (In years lost birthday) 52 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) NEBRASKA										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH MONTGOMERY County, Md.																			
10. CITY OR TOWN OF DEATH SILVER SPRING, MD										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOLY CROSS										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife										12b. KIND OF BUSINESS OR INDUSTRY own home																			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Neb. county 13b. COUNTY Montgomery										13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER 121-S. 53rd St.										13d. CITY OR TOWN SILVER SPRING																			
14. FATHER'S NAME First Thomas Middle C. Last Duffu										15. MOTHER'S MAIDEN NAME First Madeline Middle O'Connor Last										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. 508-03-5679										17. INFORMANT (husband) Joseph M. Hart Address Omaha, Nebraska 121 South 53rd Street									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral astrocytoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months										1930																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from 10/29/68 to 10/30/68, that (I) (we) lost saw the deceased alive on 10/29/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE M. Shapiro										22c. DATE SIGNED 10/30/68																													
22d. PHYSICIAN'S NAME (Type) Morton Shapiro										22e. ADDRESS 8107 Eastern Avenue, Sil. Spr., Md.										22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>																													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 11-3-1968										23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery										23d. LOCATION (City or Town) (County) (State) Omaha, Nebraska																			
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. 8434 Ga. Avenue										25a. REC'D BY REGISTRAR DATE NOV 7 1968										25b. REGISTRAR'S SIGNATURE Charles Judge																													

3523

23090 July 1952 Silver Spring, Md.

$\frac{1}{2} \times 87 = 43.5$

NOV 1 1968

CERTIFICATE OF DEATH

14635

14643

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVY CHASE</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6412 BROOKSIDE DRIVE</b>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVY CHASE</b> c. STREET ADDRESS <b>6412 BROOKSIDE DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>WITT</b> Last <b>HARVEY</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>1</b> Year <b>1968</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 27, 1912</b>	9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or retired) <b>EXECUTIVE RET.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COAL</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CHARLESTON, WEST VA.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>RALEIGH WIRT HARVEY</b>		14. MOTHER'S MAIDEN NAME <b>LAURA E. ELLIS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW 11 KOREA 579-16-9832</b>		17. INFORMANT Address <b>MRS. ORIXY S. HARVEY SAMES AS 2d</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC COMA</b> <b>571.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>POST-NECROTIC CIRRHOSIS</b> (a), stating the underlying cause last. } DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b> <b>6 yrs.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>581.0</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>16 FEB</b> 19 <b>68</b> to <b>1 OCT</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>30 SEPT</b> 19 <b>68</b> , and that death occurred at <b>8:10 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard M. Huffman,</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1 OCT 1968</b>			
22c. PHYSICIAN'S NAME (Type) <b>Richard M. Huffman, M.D.</b>		22d. ADDRESS <b>2001 Eye St., N.W., Washington, D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BOARD</b>		23b. DATE THEREOF <b>OCT. 1, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE</b>			
23d. LOCATION (City, town or county) <b>1335 H St. N. W. WASHINGTON, D.C.</b>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N. W. Washington, D. C.</b>		25a. REC'D BY REGISTRAR <b>OCT 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1963

CERTIFICATE OF DEATH

1963

NAME OF DECEASED

DATE OF DEATH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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1963 OCT 1 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 11/66

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>BLANCHE B. HAUSLER</b>			2a. DATE OF DEATH <b>10</b> Month <b>26</b> Day <b>1968</b> Year			2b. HOUR <b>1:00p</b> M.				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Aug 1 - 1888</b>		6. AGE (In years last birthday) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Wash. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.				
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carnegie Hill Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Ret. Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD -</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5101 Ridgely Rd</b>	
14. FATHER'S NAME First Middle Last <b>Albert</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Lauck Reagan</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>			16b. SOCIAL SECURITY NO. <b>577-46-7805</b>		17. INFORMANT <b>Joseph Hausler, HUSB.</b>		Address <b>5101 Ridgely Rd</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129 Aortic Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardio-Vascular Disease - years</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4221 Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221 Diabetes Mellitus</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>10/22/1968</b> , to <b>10/26/1968</b> , that (I) (we) lost saw the deceased alive on <b>10/26/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Harold I. Passes MD</b>				22c. DATE SIGNED <b>10/26/68</b>		22d. PHYSICIAN'S NAME (Type) <b>HAROLD I. PASSES MD</b>				
22e. ADDRESS <b>8612 Hartsdale Ave Bethesda Md.</b>										
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE <b>10-29-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Montgomery Co.</b>				
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc., 3130 Wisc. Ave. N.W., Wash., D.C., 20016</b>						25a. REC'D BY REGISTRAR <b>DATE OCT 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



14831

14831

UNITED STATES

DEPARTMENT OF

THE ARMY

OFFICE OF THE

CHIEF OF STAFF

WASHINGTON, D.C.

2000

1000

500

250

125

62.5

31.25

15.625

7.8125

3.90625

1.953125

0.9765625

0.48828125

0.244140625

0.1220703125

0.06103515625

0.030517578125

0.0152587890625

0.00762939453125

0.003814697265625

0.0019073486328125

0.00095367431640625

0.000476837158203125

0.0002384185791015625

0.00011920928955078125

0.000059604644775390625

0.0000298023223876953125

0.00001490116119384765625



14637

CERTIFICATE OF DEATH

14645

1. DECEASED-NAME (Type or print) <b>First Lelia Elizabeth</b> <b>Last Hellen</b>		2a. DATE OF DEATH Month <b>Oct.</b> Day <b>13</b> Year <b>68</b>		2b. HOUR <b>2:30</b> PM
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>9/29/194</b>		6. AGE (In years last birthday) <b>74</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Alabama</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Montgomery</b>		13b. CITY OR TOWN <b>Patomas</b>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>8815 Tuckerman Lane</b>
14. FATHER'S NAME First <b>(Unknown)</b> Middle <b>Pearce</b> Last <b>McLemore</b>		15. MOTHER'S MAIDEN NAME First <b>Lelia</b> Middle <b>McLemore</b> Last <b>McLemore</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Same as above</b> <b>Rev. James A. Hellen</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1702</b> IMMEDIATE CAUSE (a) <b>metastatic ca. dorsal &amp; lumbar spine</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1962 arteriosclerotic heart disease &amp; cong. Bicuspid</b>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 19 <b>68</b> , to <b>10-12</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10-12</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>John M. Wyman</b>		22c. DATE SIGNED <b>10/12/68</b>		22d. PHYSICIAN'S NAME (Type) <b>JOHN M WYMAN</b>
22e. ADDRESS <b>7801 NORFOLK AVE, Bethesda, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-17-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>High Hill Cemetery</b>	
23d. LOCATION (City or Town) <b>Lake, Mississippi</b>		23e. LOCATION (County) (State)		
24. FUNERAL DIRECTOR <b>Robert A. Humphrey</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
ANNA			Heltzman			Oct 7 1968			5:40 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		white		7/3/04		64 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
ROMAN		U.S.A.				Montgomery Co.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
SILVER SPRING			Holy Cross Hospital			HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.			MONT.		SILVER SPR.			1427 CHILTON DR.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
SAMUEL			WARSAW			CHARA BAUMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
NO			NONE		HARRY W. HELTZMAN		JAMES A 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Pneumonia, right lower lobe									1 week
481x DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 490x									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
1 Cerebral thrombosis 2 Rheumatoid arthritis 3 Malnutrition and dehydration									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept 27, 1968, to Oct 7, 1968, that (I) (we) last saw the deceased alive on Oct 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
George S. Kenton, M.D.								10/7/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
George S. Kenton, M. D.				10829 Georgia Avenue Wheaton, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		10-9-68		D.C. LODGE Cem		WASHINGTON D.C.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
GOLDBERG FUNERAL HOME				4217 TOWN ST. N.W.		OCT 9 1968		Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14639

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14647

1. DECEASED NAME (Type or print) Dorothy Frances HENDERSON			2a. DATE OF DEATH Month Day Year October 21 1968		2b. HOUR 4:25 PM
3. SEX Female	4. RACE Cauc	5. DATE OF BIRTH 17 August 1916		6. AGE (In years lost birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Montgomery Md.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Naval Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington, D.C.	13b. COUNTY Washington	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4707 Reservoir Road	
14. FATHER'S NAME George HENDERSON	15. MOTHER'S MAIDEN NAME Bessie MASON	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			
16b. SOCIAL SECURITY NO.		17. INFORMANT 4707 Reservoir Road, Douglas HENDERSON Washington, D. C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bleeding esophageal varices</u> 1978 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adenocarcinoma of liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1561					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <del>XX</del> (this hospital) attended the deceased from <u>7 October</u> , 19 <u>68</u> , to <u>21 October</u> , 19 <u>68</u> , that <del>(X)</del> (we) last saw the deceased alive on <u>21 October</u> , 19 <u>68</u> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>(I)</del> (we) (did) <del>(not)</del> view the body after death.					
22b. SIGNATURE <i>T. M. Schenk</i>	DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 23 October 1968			
22d. PHYSICIAN'S NAME (Type) T. M. SCHENK, M.D.	22e. ADDRESS Naval Hospital, Bethesda, Maryland				
23a. BURIAL, CREMATION, REMOVAL TO OTHER PLACE Cremation	23b. DATE Oct. 23, 1968	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City or Town) (County) (State) Suitland, Md.		
24. FUNERAL DIRECTOR De Vol Funeral Home, 2222 Wisconsin Ave., N.W. Washington, D.C.	25a. REC'D BY REGISTRAR DATE OCT 25 1968	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

14847

14847

STATEMENT OF DEBIT

DATE	PARTICULARS	AMOUNT	BALANCE	REMARKS
1942	To Balance	100.00	100.00	
1942	By Cash	50.00	150.00	
1942	To Cash	25.00	125.00	
1942	By Cash	75.00	50.00	
1942	To Cash	25.00	25.00	
1942	By Cash	25.00	0.00	
1942	To Cash	25.00	25.00	
1942	By Cash	25.00	0.00	
1942	To Cash	25.00	25.00	
1942	By Cash	25.00	0.00	
1942	To Cash	25.00	25.00	
1942	By Cash	25.00	0.00	
1942	To Cash	25.00	25.00	
1942	By Cash	25.00	0.00	
1942	To Cash	25.00	25.00	
1942	By Cash	25.00	0.00	
1942	To Cash	25.00	25.00	
1942	By Cash	25.00	0.00	
1942	To Cash	25.00	25.00	
1942	By Cash	25.00	0.00	
1942	To Cash	25.00	25.00	
1942	By Cash	25.00	0.00	
1942	To Cash	25.00	25.00	
1942	By Cash	25.00	0.00	
1942	To Cash	25.00	25.00	
1942	By Cash	25.00	0.00	
1942	To Cash	25.00	25.00	
1942	By Cash	25.00	0.00	
1942	To Cash	25.00	25.00	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14640

14648

1. DECEASED-NAME (Type or print) John Richard Henderson			2a. DATE OF DEATH Month Day Year Oct. 30, 1968			2b. HOUR M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 27, 1877		6. AGE (in years last birthday) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Nebraska		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery Md.					
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Suburban Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Salesman			12b. KIND OF BUSINESS OR INDUSTRY Auto		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Calif.			13b. COUNTY Pomona		13c. CITY OR TOWN Pomona		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1329 W. Mission Blvd.		
14. FATHER'S NAME First Middle Last Joseph Henderson			15. MOTHER'S MAIDEN NAME First Middle Last Emily Whitney								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 547-10-8239A		17. INFORMANT Address Mrs. Clara B. Henderson 1329 W. Mission Blvd Pomona, California						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> <u>4389</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC CEREBROVASC DIS.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>337X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>ARTEREROSCLEROTIC HEART DISEASE</u> <u>PNEUMONIA</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>10/20</u> , 19 <u>68</u> , to <u>10/30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10/30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Richard H. Pollen</u> M.D. DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10/30/68</u>				
22d. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN</u>					22e. ADDRESS <u>10400 CONNECTICUT AVE, KESSINGTON MD</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>Oct. 31, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>			23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>				
24. FUNERAL DIRECTOR <u>Francis J. Collins</u>					ADDRESS <u>500 University Blvd. W.</u> <u>Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 1 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

84041

UNITED STATES DEPARTMENT OF AGRICULTURE

1952

REPORT OF THE

COMMISSIONER

OF THE GENERAL INVESTIGATIVE DIVISION

OF THE

DEPARTMENT OF AGRICULTURE

IN CONNECTION WITH THE

INVESTIGATION OF THE

ALLEGED VIOLATIONS OF THE

ANTI-RACKETEERING ACTS

IN THE MATTER OF

THE UNITED STATES OF AMERICA

VS.

JOHN J. HENRY

ET AL.

IN THE DISTRICT COURT OF THE UNITED STATES

FOR THE DISTRICT OF COLUMBIA

FILE NO. 100-100000

REPORT NO. 100-100000

DATE OF REPORT 100-100000

CERTIFICATE OF DEATH

14649

1. DECEASED-NAME (Type or print) <b>Sherman (NMN) Henig</b>			2a. DATE OF DEATH Month <b>October</b> Day <b>15</b> Year <b>1968</b>			2b. HOUR <b>6:07</b> PM				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>23 January 1922</b>		6. AGE (In years last birthday) <b>46</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		
7a. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.				
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center, NIH</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Accountant</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>US Gov't.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1218 North Belgrade Road</b>	
14. FATHER'S NAME First Middle Last <b>Moses Henig</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Sophie Slonim</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>1942-44</b>			16b. SOCIAL SECURITY NO. <b>Not Available</b>		17. INFORMANT <b>Bethesda, Maryland</b> Address <b>The Medical Records, The Clinical Center</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> <b>2051</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic myelogenous leukemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>		
								<b>4 years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>2043 Congestive Heart Failure</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <del>(X)</del> (this hospital) attended the deceased from <b>31 July</b> , 19 <b>68</b> , to <b>15 Oct.</b> , 19 <b>68</b> , that <del>(X)</del> (we) lost saw the deceased alive on <b>15 October</b> , 19 <b>68</b> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(I)</del> (we) (did) <del>(not)</del> view the body after death.										
22b. SIGNATURE <b>Robert E. Curran</b>				22c. DATE SIGNED <b>15 October 1968</b>				22d. PHYSICIAN'S NAME (Type) <b>Robert E. Curran, MD</b>		
22e. ADDRESS <b>The Clinical Center, National Institutes</b>				22f. ADDRESS <b>The Clinical Center, National Institutes</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10-16-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID MEMORIAL GARDEN</b>		23d. LOCATION (City or Town) (County) (State) <b>FALLS CHURCH VA</b>				
24. FUNERAL DIRECTOR <b>BERNARD DANZANSKY &amp; SONS - WASHINGTON DC</b>				25a. REC'D BY REGISTRAR <b>OCT 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14448

EXHIBIT OF CASE

14448

Name		Address		City		State		Zip	
						</			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14642									
14650									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
Erwin			Otto Herrmann			October 28		1968 10 P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
MALE		WHITE		2-22-02		66 YRS.		8 6	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
Germany		AMERICAN				MONTGOMERY		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
TAKOMA PARK		WASH. SAN & Hosp.		RETIRED		Soldier Home		N.W.	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
STATE		13b. COUNTY		WASH. D.C.		YES <input type="checkbox"/> NO <input type="checkbox"/>		5521 NEBRASKA AVE	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Martin			HERMANN			Marie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
No			-			PATIENTS CHART			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY EMPHYSEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
5271									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 2 Oct, 1968, to 28 Oct, 1968, that (I) (we) last saw the deceased alive on Oct 28 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thomas P. Fogarty					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/29/68		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		Md.	
Burial		11-1-1968		Gate of Heaven Cemetery		Silver Spring, Montgomery Co.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016					25a. REC'D BY REGISTRAR DATE NOV 4 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

14630

14631

RECEIVED





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14643

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14651

1. DECEASED-NAME (Type or Print)			First CHARLES			Middle Lyman			Last HERTZ			2a. DATE KNOWN OF DEATH Month 10 Day 24 Year 68			2b. HOUR 1:45 P		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 11/11/39		6. AGE (In years to birthday) 28 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		7c. DATE PRONOUNCED DEAD Month 10 Day 24 Year 68			2d. HOUR 2:15 P		
7a. BIRTHPLACE (State or foreign country) Penna.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.								
10. CITY OR TOWN OF DEATH Maryland				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Construction Foreman				12b. KIND OF BUSINESS OR INDUSTRY Road					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penna.				13b. COUNTY Adams		13c. CITY OR TOWN Fairfield		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rte. 1							
14. FATHER'S NAME First Middle Last William L. Hertz						15. MOTHER'S MAIDEN NAME First Middle Last Iva Sites											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 182-32-4403		17. INFORMANT ADDRESS Mrs. Dona Hertz, Fairfield, Pa. R.D.# 1											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 814.7 Multiple Extreme Injuries DUE TO, OR AS A CONSEQUENCE OF (b) including fractured skull with DUE TO, OR AS A CONSEQUENCE OF (c) Exsanguination Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 8120																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year 1:45 A.M. 10/24/68				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Deceased run over by dump truck while working									
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street				21f. LOCATION Street or R.F.D. No. City or town County State Viens Mill Rd. & Conn. Ave. Wheaton									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Belden R. Reap				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 10/24/1968					
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, City or town, county) Emmitsburg, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Oct. 27, 1968		23c. NAME OF CEMETERY OR CREMATORY Fairfield Union Cemetery				23d. LOCATION (City or town) (County) (State) Fairfield, Adams Co. Pa.							
24. FUNERAL DIRECTOR Clarence E. Wilson				ADDRESS Emmitsburg, Md.				25a. REC'D BY REGISTRAR DATE OCT 28 1968				25b. REGISTRAR'S SIGNATURE Charles Judge					

1968

UNITED STATES DEPARTMENT OF JUSTICE

1968

UNITED STATES DEPARTMENT OF JUSTICE



UNITED STATES DEPARTMENT OF JUSTICE

1968

1968

UNITED STATES DEPARTMENT OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14644										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14652																			
CERTIFICATE OF DEATH																																							
1. DECEASED-NAME (Type or print) <b>VIRGINIA ROSS HESS</b>										2a. DATE OF DEATH Month <b>October</b> Day <b>1</b> Year <b>1968</b>										2b. HOUR <b>11</b> M																			
3. SEX <b>Female</b>					4. RACE <b>White</b>					5. DATE OF BIRTH <b>2-21-93</b>					6. AGE (In years last birthday) <b>75</b> YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.														
7a. BIRTHPLACE (State or foreign country) <b>New York</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>Montgomery</b> Md.																								
10. CITY OR TOWN OF DEATH <b>Bethesda</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban Hosp</b>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>																								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>										13b. COUNTY <b>Montgomery</b>					13c. CITY OR TOWN <b>Bethesda</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER <b>6304 Greentree Rd.</b>														
14. FATHER'S NAME First <b>Bert</b> Middle <b>B.</b> Last <b>Ross</b>										15. MOTHER'S MAIDEN NAME First <b>Caroline</b> Middle <b>Muller</b> Last																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO. <b>B 220-32-6320</b>					17. INFORMANT <b>Officer Henry</b> Address <b>Same as above</b>																								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b>										<b>4129</b>										<b>Minutes</b>																			
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary arteriosclerosis &amp; myocardial infarction</b>										<b>4201</b>										<b>Years</b>																			
DUE TO, OR AS A CONSEQUENCE OF (c) <b>fibrin</b>																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/29</b> , 19 <b>68</b> , to <b>9/30</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>9/30</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																																							
22b. SIGNATURE <b>Robert R. Montgomery, MD.</b>										22c. DATE SIGNED <b>10/1/68</b>																													
22d. PHYSICIAN'S NAME (Type) <b>ROBERT R. MONTGOMERY</b>										22e. ADDRESS <b>5411 CEDAR LANE BETH, Md.</b>																													
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>										23b. DATE <b>10/3/68</b>										23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>										23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>									
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>										24a. ADDRESS <b>755 Wisconsin Ave</b>										24b. REC'D BY REGISTRAR <b>OCT 7 1968</b>										24c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month		Day	Year	2b. HOUR 11:25 AM		
Anna		Marie	Hill		October	16		1968			
3. SEX Female	4. RACE Caucasian		5. DATE OF BIRTH March 11, 1891		6. AGE (In years lost birthday)		7. YRS.		IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery		10. CITY OR TOWN OF DEATH Rockville			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET AND NUMBER 9717 Carrol Drive		13b. COUNTY Montgomery			
13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9717 Carrol Drive		14. FATHER'S NAME John		15. MOTHER'S MAIDEN NAME Anna		16. SOCIAL SECURITY NO. 392-28-1912	
17. INFORMANT John W. Kappel		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic Heart Disease 4200 Bilateral pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several hours many months many years		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from May, 1963, to Oct 16, 1968, that (I) (we) last saw the deceased alive on 9/17, 1968, and that (I) (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE George H. Mitchell MD		22c. DATE SIGNED Oct. 16, 1968		22d. PHYSICIAN'S NAME (Type) George H. Mitchell		22e. ADDRESS 11125 Rockville Pike, Rockville, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/18/1968	
23c. NAME OF CEMETERY OR CREMATORY Potomac Church Cemetery		23d. LOCATION (City or Town) (County) (State) Potomac Montg. Md.		24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home		25a. REC'D BY REGISTRAR DATE OCT 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 1831 Rockville Pike Rockville, Md.	



1968

STATE OF DEATH

1968

11:30 1968 16 October Hill Marie Anna

March 11, 1961 77 Comorian Lemire

U.S.A. X

Rockville

Rockville, Md. Montgomery, Thomas

John Anna Hamilton

302-28-1-12 John A. Arnold 2717 Laurel Dr. Rockville, Md.

Oct. 16, 1968

Rockville, Md. 71125 Rockville, Md. Rockville, Md.

10/18/1968 Potomac Church Cemetery Potomac, Md.

Oct 18 1968

Rockville, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>Paul Wayne Hodge</b>						2a. DATE OF DEATH Month <b>10</b> Day <b>6</b> Year <b>68</b>			2b. HOUR <b>4:28</b> M		
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>5-10-47</b>		6. AGE (In years lost birthday) <b>21</b> YRS.		IF UNDER 1 YEAR MONTHS <b>21</b> DAYS		IF UNDER 24 HRS. HOURS <b>21</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery County, Md.</b>					
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington San. &amp; Hosp.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Unemployed</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1905 Henry Road</b>			
14. FATHER'S NAME First <b>Paul</b> Middle <b>R.</b> Last <b>Hodge</b>		15. MOTHER'S MAIDEN NAME First <b>Eva</b> Middle <b>Fisher</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-44-9895</b>		17. INFORMANT Address <b>Rondld W. Seaman Step-father Same as above</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Reticulum cell sarcometosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Reticulum cell sarcoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>2000</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>2 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>2000</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>Sept 18, 1968</b> , to <b>Oct. 6, 1968</b> , that (I) <del>(we)</del> saw the deceased alive on <b>Oct 6, 1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.											
22b. SIGNATURE <b>Donald W. Datlow, M.D.</b>						DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Oct 6, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Donald W. Datlow, M. D.</b>						22e. ADDRESS <b>Washington San. &amp; Hospital Takoma Park, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/10/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Chapel Cemetery</b>		23d. LOCATION (City or Town) <b>Hot Springs</b> (County) <b>Virginia</b> (State)					
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove column papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14647										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14655			
1. DECEASED-NAME (Type or print) First Middle Last EMMA D. Hodgson										2a. DATE OF DEATH Month Day Year 10 20 1968										2b. HOUR 4:50 A M			
3. SEX F			4. RACE W			5. DATE OF BIRTH 5-25-1886			6. AGE (In years last birthday) 82			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (State or foreign country) W. Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.														
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Potomac Valley Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Telephone Operator			12b. KIND OF BUSINESS OR INDUSTRY														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Montg			13c. CITY OR TOWN Poolesville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER											
14. FATHER'S NAME First Middle Last Thomas Hodgson			15. MOTHER'S MAIDEN NAME First Middle Last Estelle F. Smith																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 220-03-0483A			17. INFORMANT Address Chas. W. Elgin Poolesville Md														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis 4120 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years YEARS																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443X																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)														
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)						21f. LOCATION Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from 1 May, 1950, to 20 Oct, 1968, that (I) (we) last saw the deceased alive on 17 Oct 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE Edelmur Smith, MD						DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 20 Oct 68											
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS Barnesville, Md 20703																	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10/22/68			23c. NAME OF CEMETERY OR CREMATORY Greenway						23d. LOCATION (City or Town) (County) (State) Berkley Springs W. Va											
24. FUNERAL DIRECTOR Constance H. Hilton						ADDRESS Barnesville Md						25a. REC'D BY REGISTRAR OCT 24 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								

1888

RECEIVED

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## CERTIFICATE OF DEATH

14648

14656

1. DECEASED-NAME (Type or print) <b>Laura Lucinda Hopkins</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>7</b> Year <b>68</b>			2b. HOUR <b>10:30</b> <sup>P</sup>	
3. SEX <b>F</b>		4. RACE <b>C</b>		5. DATE OF BIRTH <b>8-30-82</b>		6. AGE (In years last birthday) <b>86</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> <sup>Md.</sup>	
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Montgomery General</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Sandy Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>18305 Brooke Rd.</b>		14. FATHER'S NAME First <b>Alfred</b> Middle <b>Bell</b> Last <b>Hopkins</b>		15. MOTHER'S MAIDEN NAME First <b>Eleanor</b> Middle <b>Hopkins</b> Last <b>Hopkins</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, recurrent.</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>1 YRS.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201 Chronic Pyelonephritis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/7/68</b> to <b>10/7/68</b> , that (I) ( <input checked="" type="checkbox"/> ) last saw the deceased alive on <b>10/7/68</b> , and that in (my) ( <input checked="" type="checkbox"/> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <input checked="" type="checkbox"/> ) ( <del>did</del> ) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>				22c. DATE SIGNED <b>10/8/68</b>			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10-12-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sharp Street Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Sandy Spring Montg Md.</b>	
24. FUNERAL DIRECTOR <b>Robert L Snowden Roskoche Md.</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then ~~page~~ remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1888

1888



*Handwritten text, likely a letter or document, written in cursive script. The text is mirrored across the page, suggesting it was written on lined paper and then scanned or photographed. The handwriting is somewhat faded and difficult to decipher.*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 11-68

14649		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14657			
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
Robert					Howard	Oct 22 1968		4:30 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost-birthday)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
Male		Negro		Dec 25 1900		67 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
VIRGINIA		USA				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban Hosp		Construction					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md		Mont				YES <input type="checkbox"/> NO <input type="checkbox"/>		10107 Shashbury St.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
John					Howard	Clara			? ? ?
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			No		Robt Howard Jr -		1907 Paul Rd N.W. Wash. D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus + Infection								18 hrs.	
4129 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency								2 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c) Severe Coronary Arteriosclerosis								undetermined	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4201									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
9/27/68		Gangrene Rt foot		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 9/24, 1968, to 10/22, 1968, that (I) (we) last saw the deceased alive on 10/22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						DEGREE		22c. DATE SIGNED	
J.R. Thistlethwaite						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		10/23/68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
J.R. Thistlethwaite						916 19th St. N.W.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10-26-68		Lincoln Memorial Cem		Suitland Prince Geo. Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
George R. Brandon		5000 Rockwell Rd.		OCT 31 1968		J Charles Judge			

14887

14887

Oct 1 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV.

MONTGOMERY COUNTY DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14650									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
NELLIE			DAILEY			Month 10 Day 3 Year 68		9:40 A.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE		WHITE		9-5-11		57 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		USA				MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
OLNEY		MONTGOMERY GENERAL		OWNER & MANAGER		DRESS SHOP			
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		MONTGOMERY		GERMANTOWN				Box 247, ROUTE #1	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
OBER - DAILEY			MARY - MUSGROVE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			
NO						MEDICAL RECORD DEPT.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Predominant adenocarcinoma</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Metastatic carcinoma</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u></u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
2924									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>Oct</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>Oct 3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>A. D. Bonifant</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10-3-68		
22d. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.					22e. ADDRESS MEDICAL CENTER, SANDY SPRING, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Oct. 5, 1968		Salem		Brookeville Mont. Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Francis H. Barber Laytonsville, Md.					DATE OCT 7 1968		<u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14651

CERTIFICATE OF DEATH

14659

1. DECEASED-NAME (Type or print) <b>HAROLD E. Hughes</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>11</b> Year <b>68</b>			2b. HOUR M				
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>9-12-07</b>		6. AGE (In years last birthday) <b>61</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.				
10. CITY OR TOWN OF DEATH <b>Bethesda, Md.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GROSVENOR LANE NURSING HOME</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Teller Operator</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S.S.C.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>			13b. COUNTY <b>Pro Geo E. Hyattsville</b>			13c. CITY OR TOWN <b>Pro Geo E. Hyattsville</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <b>Charles D Hughes</b>			15. MOTHER'S MAIDEN NAME <b>Leticia Thrash</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. <b>214-03-8012</b>			17. INFORMANT <b>Mildred P. Hughes E. Hyattsville, Md</b>			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>144X</b> IMMEDIATE CAUSE (a) <b>Probable Pulmonary Embolism</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of Floor of Mouth Larynx</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>24hrs.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>143X</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>May 1968</b> to <b>10/11/1968</b> , that (I) (we) last saw the deceased alive on <b>10/15/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>G. Leonard Gold</b>					DEGREE <b>DEGREE</b>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/11/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>G Leonard Gold</b>					22e. ADDRESS <b>Silver Springs, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>10/14/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>					25a. REC'D BY REGISTRAR <b>OCT 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1955

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14652

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14660

1. DECEASED-NAME (Type or Print)			First	Middle	Lost	2a. DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> Month	Day	Year	2b. HOUR	
ANTHONY				Lynn		HUGHLEY			<input type="checkbox"/> MATED	10/	7	68	5PM M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR		
Male	Negro	12/23/54	1955	MONTHS	DAYS	HOURS	MIN.	Month			Day	Year	5PM M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY				
No. Carolina		USA				Montgomery			School				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring			Holy Cross Hosp.			Student			School				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.				Montgy.		Sil. Spr.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1013 S. Belgrade Road			
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost		
Emory						Carrie			B.		Belton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			None			Father,			Emory Hughley 1013 S. Belgrade Rd. S.S., Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Multiple Injuries Severe -</u>												<u>Sudden</u>	
8147 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) <u>Trauma from blow from auto -</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
8124													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
				4:30 P.M. 10/7 1968		Struck by car when running across street.							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
		Street		1120 Arcole St.		Silver Spring		Mont.		Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				John B. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED	
EXAMINER'S NAME (Type)				John G. Ball				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				Oct. 7, 1968	
								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
								ADDRESS (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)			
Burial		10-11-1968		St. Lincoln Cemetery		Prince Georges, Maryland							
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
C. Glen Carter				DATE				OCT 11 1968		Charles Judge			
Warner E. Pumphrey, Inc. 8434 Georgia Avenue													

14880

14880

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF

CALIFORNIA

DATE

TIME

PLACE

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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## CERTIFICATE OF DEATH

14653

14661

1. DECEASED NAME (Type or print)		First Lola		Middle Nevada		Last Hurd		2a. DATE OF DEATH		Month 10		Day 1		Year 68		2b. HOUR 1:45 PM	
3. SEX F		4. RACE White		5. DATE OF BIRTH 6-24-76				6. AGE (In years last birthday) 92		IF UNDER 1 YEAR MONTHS OAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (State or foreign country) Del		7b. CITIZEN OF WHAT COUNTRY? Amer		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery						Md.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Sen & Hospit				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) H swt.				12b. KIND OF BUSINESS OR INDUSTRY NONE							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 909 Homer Ave									
14. FATHER'S NAME First Middle Last Chas R Layton				15. MOTHER'S MAIDEN NAME First Middle Last Margaret Sipple													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 222-20-8592		17. INFORMANT Hospital Records													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure &amp; Cardiac Arrest</u> 887X DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple Fractures &amp; Overwhelming Shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>9040</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Senility</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-10 min 7 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> <u>Fracture of right clavicle, pelvis &amp; Ribs - Right</u> <u>2-8</u>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>Sept 24 1968</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) <u>Patient fell in her bedroom.</u>													
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <u>home</u>		21f. LOCATION Street or R.F.D. No. City or Town <u>909 Homer Ave</u> <u>Takoma</u> <u>Mont.</u> <u>MD</u>													
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 24</u> , 1968, to <u>Oct 1</u> , 1968, that (II) (we) last saw the deceased alive on <u>Oct 1</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (II) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Wilford D. Meyers M.D.</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>Oct 1, 1968</u>											
22d. PHYSICIAN'S NAME (Type) <u>Wilford D. Meyers M.D.</u>				22e. ADDRESS <u>8323 Haddon Drive</u> <u>Takoma</u> <u>Park</u> <u>Mont. Md</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct. 4, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Barratt's Chapel Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Frederica</u> <u>Kent</u> <u>Delaware</u>											
24. FUNERAL DIRECTOR <u>William B. Wilford, Del</u>				ADDRESS <u>8323 Haddon Drive</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 3 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 5-64  
30M REV. 1-68

14654

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14662

1. DECEASED-NAME (Type or print) <u>Claude G. Inman</u>			2a. DATE OF DEATH Month <u>10</u> Day <u>5</u> Year <u>1968</u>			2b. HOUR <u>8:50 a.m.</u>	
3. SEX <u>male</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH <u>1/26/08</u>		6. AGE (In years last birthday) <u>60</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>England</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.	
10. CITY OR TOWN OF DEATH <u>Silver Spg.</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Trinity Cross Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Gov't Employ.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Cherry Chase</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>7004 Georgia St.</u>		14. FATHER'S NAME First Middle Last <u>Oliver Inman</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>unknown</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <u>no</u>		16b. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Harold Inman</u>		Address <u>7004 George St Cherry Chase Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple pulmonary emboli</u> <u>189.0</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertrophoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few weeks</u> <u>years</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <u>180x</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>68</u> , to <u>10/5</u> , 19 <u>68</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>10/5</u> , 19 <u>68</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.							
22b. SIGNATURE <u>G. Leonard Gold</u> DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>10/5/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>G. LEONARD GOLD</u>				22e. ADDRESS <u>9801 Georgia Ave. Silver Spring, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-8-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 9 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14653										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14663									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
ANNA M. JACKSON										10 24 1968										4 05 PM									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 MRS.			IF UNDER 1 YEAR			IF UNDER 24 MRS.								
FEMALE			WHITE			2/28/82			86 YRS.			MONTHS			DAYS			HOURS			MIN.								
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH										Md.										
WISCONSIN			USA						MONTGOMERY																				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					12b. KIND OF BUSINESS OR INDUSTRY														
BETHESDA					SUBURBAN					HOUSEWIFE																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE					13b. COUNTY					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER									
MARYLAND					MONTGOMERY					CHEVY CHASE					YES					6913 RIDGEWOOD AVE.									
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last																								
JOSEPH JEROME ADAMS					CARRIE H. BRAHMSTEAD																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO.					17. INFORMANT					Address														
NO					213-56-7589					HARTLEY JACKSON (HUSBAND)					6913 RIDGEWOOD AVE.														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																													
PART I. DEATH CAUSED BY:																													
IMMEDIATE CAUSE (a) Myocardial infarction, recent and remote																													
DUE TO, OR AS A CONSEQUENCE OF																													
(b) Arteriosclerosis, generalized, severe																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
Reticulum cell sarcoma																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 26 April, 1968, to date, 1968, that (I) (we) last saw the deceased alive on Oct 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE John E. Ball										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED Oct 25, 1968														
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)														
Removal-Burial 10-28-1968					Evergreen Cemetery Cem.					Milton, Wisconsin																			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., N.W., Wash., D.C., 20016										ADDRESS 5130 Wisc. Ave.					25a. REC'D BY REGISTRAR DATE OCT 30 1968					25b. REGISTRAR'S SIGNATURE Charles Judge									

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
1. DECEASED-NAME (Type or print) First Middle Last <b>Helen Karst JACKSON</b>					2a. DATE OF DEATH Month Day Year <b>Oct. 28 28 68</b>			2b. HOUR <b>345A M</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Aug. 29, 1922</b>		6. AGE (In years last birthday) <b>46</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Florida</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Naval Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE <b>Florida</b>		13b. COUNTY <b>Orange</b>		13c. CITY OR TOWN <b>Maitland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>341 Dommerich Drive</b>	
14. FATHER'S NAME First Middle Last <b>Emil E. Karst</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Bessie Furbeck</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>263 242571</b>		17. INFORMANT Address <b>Maitland Fla. Col Joseph C. Jackson, USA 341 Dommerich Dr.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia associated with acute peritonitis</b> <b>0389</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>0534</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (a) (this hospital) attended the deceased from <b>Jul. 24</b> , 19 <b>68</b> , to <b>Oct. 28</b> , 19 <b>68</b> , that <del>xx</del> (we) lost saw the deceased alive on <b>Oct. 28</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Donald K. Roeder</b> M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED <b>Oct. 28, 1968</b>				
22d. PHYSICIAN'S NAME (Type) <b>Donald K. Roeder, M. D.</b>					22e. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-30-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Orlando, Fla.</b>			
24. FUNERAL DIRECTOR <b>Danzansky Funeral Home</b> <b>3501 14th St., N. W. Washington, D. C.</b>					25a. REC'D BY REGISTRAR <b>OCT 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

MEDICAL CERTIFICATION

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*Journal of Management Studies*, 2006; 43(7): 987-1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																							
CERTIFICATE OF DEATH																							
14657																							
14665																							
1. DECEASED-NAME (Type or print) <b>Eva</b>			First <b>Eva</b>			Middle <b>(NMN)</b>			Last <b>Jaczk</b>			2a. DATE OF DEATH Month <b>October</b> Day <b>27</b> Year <b>1968</b>			2b. HOUR P <b>12:45M</b>								
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>June 25, 1882</b>			6. AGE (In years lost birthday) <b>86</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.								
7a. BIRTHPLACE (State or foreign country) <b>Hungary</b>			7b. CITIZEN OF WHAT COUNTRY? <b>Hungary</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b>			10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center, NIH</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Silver Spring</b>			13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			13e. STREET AND NUMBER <b>11503 Alma Street</b>			14. FATHER'S NAME First <b>Francis</b> Middle <b>Michkey</b> Last <b>Miskey</b>			15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Teleky</b> Last <b>Deloky</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>278-09-3215-B</b>			17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Md. 20014</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myelogenous Leukemia</b> <b>2051</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>2041</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			22a. I certify that (I) (this hospital) attended the deceased from <b>October 17, 1968</b> , to <b>October 27, 1968</b> , that (I) (we) last saw the deceased alive on <b>October 27, 1968</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <b>David A. Bray MD</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>27 October 1968</b>								
22d. PHYSICIAN'S NAME (Type) <b>David A. Bray, M.D.</b>			23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>10-30-1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Sil. Spr. Montgomery Md.</b>			24. FUNERAL DIRECTOR <b>C. Glen Carter</b> ADDRESS <b>Sil. Spr. Md.</b>			25a. REC'D BY REGISTRAR <b>OCT 31 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		
25c. REGISTRAR'S SIGNATURE <b>Warner E. Pumphrey, Inc. 8434 Ga. Ave.</b>			25d. REGISTRAR'S SIGNATURE			25e. REGISTRAR'S SIGNATURE			25f. REGISTRAR'S SIGNATURE			25g. REGISTRAR'S SIGNATURE			25h. REGISTRAR'S SIGNATURE			25i. REGISTRAR'S SIGNATURE					

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

Items 18-22a Film 406 State Department of Health  
11-19-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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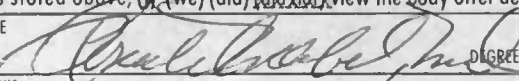
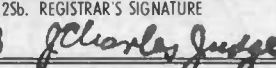
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First Middle Last Joan K Jenkins			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year 10-27 1968			2b. HOUR 12:20 A.M.							
3. SEX female		4. RACE white		5. DATE OF BIRTH July 18, 1938		6. AGE (In years last birthday) 30 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD Month 10 Day 27 Year 1968		2d. HOUR 12:30 A.M.	
7a. BIRTHPLACE (State or foreign country) Baltimore			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Montgomery Md.				
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Holy Cross Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland				13b. COUNTY HOWARD				13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Aladdin Drive 1520 Aladin Dr.	
14. FATHER'S NAME Thomas N. Eagleson				15. MOTHER'S MAIDEN NAME Josephine Cuneo									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Robert E. Jenkins, husband, above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation due to aspiration</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>of gastric contents</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 9210													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR <u>11:50</u> M. <u>10-26</u> 19 <u>68</u>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Deceased vomited and aspirated vomitus					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home				21f. LOCATION Street or R.F.D. No. City or Town County State Laurel Howard Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Belden R. Reap				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 10/27/1968					
EXAMINER'S NAME (Type) BELDEN R. REAP M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (City, State, and County) Belair Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 10/31/68		23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens				23d. LOCATION (City or Town) (County) (State) Belair Md.			
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane						ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 30 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last <b>Carl A. Johnson</b>						2a. DATE OF DEATH Month Day Year <b>October 18 1968</b>		2b. HOUR A M <b>4:00 M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>23 August 1916</b>		6. AGE (In years last birthday) <b>52</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>The Clinical Center, NIH</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Restaurant Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Ohio</b>		13b. COUNTY <b>W. Carrollton</b>		13c. CITY OR TOWN <b>W. Carrollton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1437 South Elm Street</b>	
14. FATHER'S NAME First Middle Last <b>Grover C. Johnson</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Lillian M. Adams</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>379-09-0189</b>		17. INFORMANT The Medical Record Address <b>The Clinical Center, NIH, Bethesda, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Degeneration and impaction of silicone prosthetic/</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>anterolateral myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Rheumatic heart disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 weeks</b> <b>20 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from <b>23 August, 1968, to 18 Oct., 1968</b> , that (X) (we) lost saw the deceased alive on <b>18 October 1968</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 		22c. DATE SIGNED <b>18 October 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>Ronald M. Abel, M.D.</b>		22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 22, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodland Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Zenia Greene Ohio</b>			
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b> <b>1331 Rockville Pike, Rockville, Maryland</b>				25a. REC'D BY REGISTRAR <b>OCT 22 1968</b>		25b. REGISTRAR'S SIGNATURE 			

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14660

CERTIFICATE OF DEATH

14668

|   |  |  |   |  |   |   |   |  |  |   |  |
|---|--|--|---|--|---|---|---|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Jeffrey Miles JOHNSON</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>October</b> Day <b>8</b> Year <b>68</b>                                 |  |   | 2b. HOUR<br><b>900P M</b>   |   |  |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br><b>March 18, 1961</b>  |   | 6. AGE (In years last birthday)<br><b>7</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN <b></b> |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>California</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.   |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Naval Hospital</b> |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>N/A</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Virginia</b>  |  |  | 13b. COUNTY<br><b>Quantico</b>  |  | 13c. CITY OR TOWN<br><b>Quantico</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>Quarters 2780-C</b>   |   |  |
| 14. FATHER'S NAME First Middle Last<br><b>Harold Larue Johnson</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Catherine Mary Hanlin</b>   |   |   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT <b>Quantico, Va.</b> Address<br><b>Harold Larue Johnson, Quarters 2780-C, MCB</b>                                 |   |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>5933</b> IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema secondary to Uremia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>secondary to Obstructive (Clinical) due to</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Obstructive Uropathy</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>603X</b>   |  |  |   |  |   |   |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>yes</b>              |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>            |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |   |  |  |   |  |
| 22a. I certify that <b>it</b> (this hospital) attended the deceased from <b>Oct. 5</b> , 19 <b>68</b> , to <b>Oct. 8</b> , 19 <b>68</b> , that <b>it</b> (we) last saw the deceased alive on <b>Oct. 8</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>it</b> (we) (did) (did not) view the body after death.  |  |  |   |  |   |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>James L. Snyder</b> M.D. DEGREE  |  |  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   |   | 22c. DATE SIGNED<br><b>Oct. 9, 1968</b>        |  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>L. L. Snyder</b>   |  |  |   |  | 22e. ADDRESS<br><b>Naval Hospital, Bethesda, Md.</b>  |   |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>14 Oct. 68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Arlington, Va.</b>                          |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>B. Dan Mountcastle</b><br><b>Cunningham Mount Castle</b><br><b>Mineral Home</b>  |  |  |   |  | ADDRESS<br><b>Occoquan &amp; Harner St.</b><br><b>Woodbridge, Virginia</b>  |   | 25a. REC'D BY REGISTRAR<br><b>OCT 14 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |   |  |



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Figure 1: The research design.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14661

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14669

|  |                         |  |  |   |   |   |   |   |
|--|-------------------------|--|--|---|---|---|---|---|
| 1. DECEASED-NAME<br>(Type or Print) <i>Charles Harvey Jones</i>  |                         |  | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> Month <i>Oct</i> Day <i>28</i> Year <i>1968</i> |   |   | 2b. HOUR OF DEATH<br><i>9:20</i> M  |   |   |
| 3. SEX<br><i>male</i>  | 4. RACE<br><i>white</i> | 5. DATE OF BIRTH<br><i>5-23-43</i>   | 6. AGE (In years last birthday)<br><i>25</i> YRS.  | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____  | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____                              | 2c. DATE PRONOUNCED DEAD<br>Month <i>Oct</i> Day <i>28</i> Year <i>1968</i>                     |   |   |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Montgomery</i> Md.   |   |   |
| 10. CITY OR TOWN OF DEATH<br><i>Bethesda</i>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Suburban</i>        |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Cond. Worker</i>  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>   |                         | 13b. COUNTY<br><i>Prince George</i>  |  | 13c. CITY OR TOWN<br><i>Bladensburg</i>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER<br><i>4317 57th Ave</i>                |
| 14. FATHER'S NAME<br>First <i>Thomas</i> Middle <i>E.</i> Last <i>Jones Sr.</i>  |                         |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Violet</i> Middle <i>L.</i> Last <i>Thomas</i>                            |   |   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <i>No</i>  |                         |  | 16b. SOCIAL SECURITY NO.<br><i>220-40-7034</i>   |   | 17. INFORMANT<br><i>Bra Lee Jones</i> ADDRESS<br><i>Bladensburg, Md</i> |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Massive intra-pulmonary hemorrhage, right</i><br><i>883X</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Puncture wounds from fractured ribs</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Trauma from accidental fall down elevator shaft</i> |                         |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Sudden</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>9026</i>  |                         |  |  |   |   |   |   |   |
| 19a. DATE OF OPERATION   |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                         | 21b. TIME OF INJURY Month, Day, Year<br><i>9:00 A.M. 10-28 1968</i>                                    |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)<br><i>Fall down elevator shaft at work</i>                                  |   |   |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><i>Office Building</i> |  | 21f. LOCATION Street or R.F.D. No.<br><i>Peers Park</i>   |   | City or Town<br><i>Smithsburg</i>   |   | County<br><i>Montgomery</i> State<br><i>Md</i>                |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                           |                         |  |  |   |   |   |   |   |
| ACTUAL SIGNATURE<br><i>John G. Ball</i>  |                         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |   | 22b. DATE SIGNED<br><i>Oct 28, 1968</i>   |   |   |
| EXAMINER'S NAME (Type)<br><i>John G Ball</i>   |                         |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                     |   |   |
|  |                         |  | ADDRESS (Street, city, town, or county)<br><i>John G Ball</i>  |   |   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                         | 23b. DATE<br><i>Oct 31, 1968</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Whitfield Cemetery</i>   |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Lanham Pro Geo Md.</i>                      |   |   |
| 24. FUNERAL DIRECTOR<br><i>F. Gasch's Sons</i>   |                         |  |  | ADDRESS<br><i>Hyattsville, Md.</i>  |   | 25a. REC'D BY REGISTRAR<br>DATE <i>NOV 1 1968</i>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>            |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14662

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
 CERTIFICATE OF DEATH

14670

|  |  |  |  |   |   |   |   |  |                                   |  |                                |
|--|--|--|--|---|---|---|---|--|-----------------------------------|--|--------------------------------|
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First  | Middle  | Last  | 2a. DATE OF DEATH<br>Month Day Year   |   |  | 2b. HOUR P                        |  |                                |
| Gertrude Evelyn Jones  |  |  |  |   |   | October 17 1968   |   |  | 11:50 M                           |  |                                |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |   |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS    |  | IF UNDER 24 HRS.<br>HOURS MIN. |
| Female   |  | White  |  | 2/26/84   |   |   | 84 YRS.   |  |                                   |  |                                |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. COUNTY OF DEATH<br>Md.   |  |                                   |  |                                |
| England  |  | ? England  |  |   |   |   | Montgomery  |  |                                   |  |                                |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                                |
| Olney  |  |  | Montgomery General Hospital  |   |   | Housewife   |   |  |                                   |  |                                |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN                               |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER            |  |                                |
| Maryland   |  |  | Montgomery   |   | Damascus  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                             |  | 9886 Main street                  |  |                                |
| 14. FATHER'S NAME<br>First Middle Last   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last                                |   |   |   |   |  |                                   |  |                                |
| Robert Watson  |  |  | Anna Truckette   |   |   |   |   |  |                                   |  |                                |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address                           |   |   |  |                                   |  |                                |
| no   |  |  | 129-38-8103  |   | records Montgomery General Hospital, Olney, Md. |   |   |  |                                   |  |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Recurrent Cerebral Thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Cerebral Arteriosclerosis</b><br>(b) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |   |   |   |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 days</b><br><b>15 years</b><br><b>15 years</b> |                                |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>1. Acute Pneumonitis 2. Diabetes Mellitus</b>   |  |  |  |   |   |   |   |  |                                   |  |                                |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                   |                                   |  |                                |
| No Operation   |  |  |  |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |   |  |                                   |  |                                |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>No Injury</b>   |   |   |   |  |                                   |  |                                |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |  |                                   |  |                                |
|  |  |  |  |   |   |   |   |  |                                   |  |                                |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>July 12, 1968</b> , to <b>October 17, 1968</b> , that (I) (we) saw the deceased alive on <b>October 17, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |   |  |                                   |  |                                |
| 22b. SIGNATURE<br><i>M. McKendree Boyer</i>  |  |  |  |   |   | DEGREE<br>ATTENDING PHYS.   |   | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                   | 22c. DATE SIGNED<br><b>October 18, 1968</b>  |                                |
| 22d. PHYSICIAN'S NAME (Type)<br><b>M. McKendree Boyer, M.D.</b>  |  |  |  |   |   | 22e. ADDRESS<br><b>9701 Church Street, Damascus, Maryland</b>                           |   |  |                                   |  |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE<br><b>Oct. 20, 1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Damascus Meth.</b>   |   |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Damascus, Md.</b>                  |                                   |  |                                |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Olin L. Molesworth, Damascus, Md.</b>   |  |  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 22 1968</b>                                      |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                                     |                                   |  |                                |

14878

UNITED STATES



13 days  
13 years  
13 years

Government General Information  
General Information  
Administrative Information

Acute Inflammation of the Stomach

No Inflammation

No Injury

October 15, 1961  
October 15, 1961  
October 15, 1961

October 15, 1961

Oct 15 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14668

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14671

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>IRENE CAMPBELL JONES</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>OCT</b> Day <b>31</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>8 P M</b>   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br><b>AUG. 8, 1889</b>   |  | 6. AGE (In years last birthday)<br><b>79</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>MONTGOMERY</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TAKOMA PARK</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>7777 MAPLE AVE.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>RET. - U.S. GOVT.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>GOVT.</b>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>   |  | 13b. COUNTY<br><b>MONTG. TAKOMA PK.</b>  |  | 13c. CITY OR TOWN<br><b>TAKOMA PK.</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>7777 MAPLE AVE.</b>   |  | 14. FATHER'S NAME<br>First <b>BRADLEY</b> Middle <b>BRADLEY</b> Last <b>BRADLEY</b>                    |  | 15. MOTHER'S MAIDEN NAME<br>First <b>—</b> Middle <b>—</b> Last <b>—</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) <b>—</b>               |  |
| 16b. SOCIAL SECURITY NO.<br><b>216-46-1395</b>   |  | 17. INFORMANT<br><b>ALLAN L. DREW, III, BOWIE, MD.</b>   |  | 18. ADDRESS<br><b>BOWIE, MD.</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br><b>2509</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Decayed Vessels</b> |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>260X</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                      |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                           |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  | 22c. DATE SIGNED<br><b>11-1-68</b>   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/27</b> , 19 <b>61</b> , to <b>10/31</b> , 19 <b>68</b> , that (I) (we) just saw the deceased alive on <b>10-25</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>A. Betz</b>   |  | 22d. PHYSICIAN'S NAME (Type)<br><b>ANDREW J. BETZ</b>  |  | 22e. ADDRESS<br><b>2906 WELLS RD, SILVER SPRING, MD.</b>  |  | 22c. DATE SIGNED<br><b>11-1-68</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>11/4/68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>SILVER SPRING, MD.</b>                   |  |
| 24. FUNERAL DIRECTOR<br><b>JOS. GAWLER'S SONS, 5130 WIS. AVE., WASH., D.C.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>NOV 7 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

1967

1100

DATE OF BIRTH

JANE CAMPBELL JAMES

WHITE

U.S.A.

1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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*cleared with medical examiner 10/25/68*

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |   |  |  |   |  |
|---|--|--|--|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |   |  |
| CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |   |  |
| 1. DECEASED-NAME (Type or print) <b>LORRAINE H. JONES</b>   |  |  |  |  | 2a. DATE OF DEATH<br>Month <b>10</b> Day <b>25</b> Year <b>68</b>                 |  |  | 2b. HOUR <b>7:30</b> <sup>P</sup> <sub>M</sub>  |  |
| 3. SEX <b>F.</b>  |  | 4. RACE <b>W.</b>  |  | 5. DATE OF BIRTH <b>5/20/09</b>  |   | 6. AGE (In years last birthday) <b>59</b> <del>58</del> YRS.                                 |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                       |  |
| 7a. BIRTHPLACE (State or foreign country) <b>D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>MONT.</b>  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOLY CROSS Hosp.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if <del>on</del> <sup>at</sup> home) <b>Room Housewife</b>                    |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>   |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>  |  | 13b. COUNTY <b>MONT.</b>   |  | 13c. CITY OR TOWN <b>SILVER SPRING</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <b>10309 INSLY ST.</b>   |  |
| 14. FATHER'S NAME First <b>Garrow</b> Middle <b>Veirs</b> Last <b>Martha</b>  |  | 15. MOTHER'S MAIDEN NAME First <b>Eva</b> Middle <b>Bryant</b> Last <b>Silver Spr. Md.</b>           |  |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)  |  | 16b. SOCIAL SECURITY NO. <b>VE-5</b>   |  | 17. INFORMANT <b>Revelle D. Jones 10309 Insley Street</b>  |   |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Emotion; electrolyte imbalance</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Biliary Cirrhosis</b>  |  |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>mins.</b><br><b>days.</b><br><b>2 yrs.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>5810</b>  |  |  |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                                    |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |   |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>December, 1967</b> , to <b>October 25, 1968</b> , that (I) (we) last saw the deceased alive on <b>October 25, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |  |   |  |
| 22b. SIGNATURE <b>Harold W. Draper, M.D.</b> DEGREE <b>MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  | 22c. DATE SIGNED <b>10/25/68</b>   |   |  |  |   |  |
| 22d. PHYSICIAN'S NAME (Type) <b>HAROLD W. DRAPER, M.D.</b>  |  |  |  | 22e. ADDRESS <b>9601 Ga. Ave. Silver Spring</b>  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE <b>10-29-1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Maryland</b>                 |  |   |  |
| 24. FUNERAL DIRECTOR <b>C. Glen Carter</b> ADDRESS <b>Sil. Spr. Md.</b>   |  |  |  | 25a. REC'D BY REGISTRAR <b>OCT 31 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |   |  |
| Warner E. Pumphrey, Inc. 8434 Ga. Avenue  |  |  |  |  |   |  |  |   |  |



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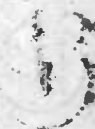
VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |         |  |  |   |   |   |  |                                |  |
|---|---------|--|--|---|---|---|--|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |  |  |   |   |   |  |                                |  |
| CERTIFICATE OF DEATH  |         |  |  |   |   |   |  |                                |  |
| 1. DECEASED-NAME<br>(Type or print)   |         |  | First Middle Last  |   |   | 2a. DATE OF DEATH   |  |                                | 2b. HOUR                                     |
| Thomas WALTER JONES   |         |  |  |   |   | 10 - 10 - 1968  |  |                                | 5:25 AM                                      |
| 3. SEX  | 4. RACE |  | 5. DATE OF BIRTH   |   |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR<br>MONTHS DAYS |  |
| male  | white   |  | 12/6/194   |   |   | 73 YRS.   |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |                                |  |
| D.C.  |         | U.S.A.   |  |   |   | Montgomery Co. Md.  |  |                                |  |
| 10. CITY OR TOWN OF DEATH   |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |                                | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Silver Spring   |         |  | Holy Cross Hospital  |   |   |   |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE   |         |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  | 13e. STREET AND NUMBER         |  |
| MD.   |         |  | MONTG.   |   | SL. SP.   |   |  | 8107 EASTERN AVE.              |  |
| 14. FATHER'S NAME   |         |  | 15. MOTHER'S MAIDEN NAME   |   |   |   |  |                                |  |
| First Middle Last   |         |  | First Middle Last  |   |   |   |  |                                |  |
| William E. Jones  |         |  | Ann A. Hagan   |   |   |   |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  |         |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address   |   |  |                                |  |
| No  |         |  |  |   | HOSPITAL RECORDS.   |   |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |  |   |   |   |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |         |  |  |   |   |   |  |                                |  |
| IMMEDIATE CAUSE (a) <u>Pneumonia &amp; Congestive Heart Failure</u>   |         |  |  |   |   |   |  |                                | 2 days                                       |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |   |   |   |  |                                |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>485X</u>  |         |  |  |   |   |   |  |                                |  |
| (b) <u>aspiration.</u>  |         |  |  |   |   |   |  |                                |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |   |   |   |  |                                |  |
| (c)   |         |  |  |   |   |   |  |                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)  |         |  |  |   |   |   |  |                                |  |
| <u>Loeffer's cirrhosis, diabetes mellitus, gangrene @ lower extremity, arteriosclerotic cerebral vascular disease</u>   |         |  |  |   |   |   |  |                                |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                |  |
|   |         |  |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | yes  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |         | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |   |   |  |                                |  |
|   |         | HOUR A.M. Month Day Year<br>P.M. 19  |  |   |   |   |  |                                |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |         | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION   |   | Street or R.F.D. No.  |  | City or Town                   | County State                                 |
|   |         |  |  |   |   |   |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/23</u> , 19 <u>60</u> , to <u>10/10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10/9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |         |  |  |   |   |   |  |                                |  |
| 22b. SIGNATURE  |         |  |  | DEGREE  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED               |  |
| Bernard A. Heckman, M.D.  |         |  |  |   |   |   |  | 10/10/68                       |  |
| 22d. PHYSICIAN'S NAME (Type)  |         |  |  | 22e. ADDRESS  |   | 22f. ADDRESS  |  |                                |  |
| Bernard A. Heckman  |         |  |  |   |   | 8107 Eastern Ave., Silver Spring, Md. 20910   |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town)  |  | (County)                       | (State)                                      |
|   |         | 10-14-68   |  | MT. OLIVET  |   | WASH.   |  |                                | D.C.   |
| 24. FUNERAL DIRECTOR ADDRESS  |         |  |  | 25a. REC'D BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE  |  |                                |  |
| Hanson Funeral Home 4748 Wisc. Ave  |         |  |  | OCT 15 1968   |   | Charles Judge   |  |                                |  |

1987

INSTITUTIONAL

1987



CHIEF OF BUREAU

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1987

1987

1987

1987

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14666

14674

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                            |   |   |  |
|--|----------------------------|---|---|--|
| 1. DECEASED NAME<br>(Type or Print) <b>Renee R. Jordan</b>   |                            | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <b>Oct 1968</b>                    |   | 2b. HOUR <b>?</b> M <b>M</b>   |
| 3. SEX <b>Fe.</b>  | 4. RACE <b>W.</b>          | 5. DATE OF BIRTH <b>Nov 19/1894</b>   | 6. AGE (In years last birthday) <b>73</b> YRS | 2c. DATE PRONOUNCED DEAD <b>Oct 3</b> Day <b>3</b> Year <b>1968</b>  |
| 7a. BIRTHPLACE (State or foreign country) <b>Great Britain</b>   |                            | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 9. COUNTY OF DEATH <b>Montgomery</b>   |                            | 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>  |   |  |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>8700 Cokesville Rd.</b>  |                            | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |                            | 13b. COUNTY <b>Montgomery</b>   |   | 13c. CITY OR TOWN <b>Silver Spring</b>   |
| 14. FATHER'S NAME <b>(Unknown)</b>   |                            | 15. MOTHER'S MAIDEN NAME <b>(Unknown)</b>   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>  |                            | 16b. SOCIAL SECURITY NO. <b>None</b>  |   | 17. INFORMANT <b>Mr. J. Robert Taylor</b> ADDRESS <b>Wheaton, Maryland</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>433.9 Infarction cerebri</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>cerebral arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>(b) DUE TO, OR AS A CONSEQUENCE OF</b><br>(c)   |                            |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>332X</b>   |                            |   |   |  |
| 19a. DATE OF OPERATION   |                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                            | 21b. TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. <b>P.M.</b>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                            | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                            |   |   |  |
| ACTUAL SIGNATURE <b>John G. Ball</b>   |                            | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   | 22b. DATE SIGNED <b>Oct 4, 1968</b>  |
| EXAMINER'S NAME (Type) <b>John G. Ball</b>   |                            | ADDRESS (Street, city, town, or county)   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 23b. DATE <b>10-8-1968</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>  |
| 24. FUNERAL DIRECTOR <b>M. Andrew Duwall</b>   |                            | ADDRESS <b>M. Andrew Duwall, Sil. Spr. Md.</b>  |   | 25a. REC'D BY REGISTRAR <b>Charles Judge</b>   |
| Warner E. Pumphrey, Inc. 8434 Georgia Avenue   |                            | DATE <b>OCT 10 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE   |

1967

UNITED STATES DEPARTMENT OF JUSTICE

1967

RECEIVED



1967



1967-10-10  
1967-10-10  
1967-10-10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14667

## CERTIFICATE OF DEATH

14675

|  |                                     |   |  |   |  |
|--|-------------------------------------|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br>Mirian Z. Kaitlin   |                                     |   | 2a. DATE OF DEATH<br>10 Month 4 Day 68 Year 12/10/51 M |   | 2b. HOUR   |
| 3. SEX<br>Female   | 4. RACE<br>White                    | 5. DATE OF BIRTH<br>Jan. 15, 1923   |  | 6. AGE (In years last birthday)<br>45 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br>Montgomery Md.                   |   |  |
| 10. CITY OR TOWN OF DEATH<br>Takoma Park   |                                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Washington San. & Hosp.   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Receptionist |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |                                     | 13b. COUNTY<br>Montgomery   | 13c. CITY OR TOWN<br>Silver Spg.                       | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         | 13e. STREET AND NUMBER<br>11617 Lockwood Dr.                     |
| 14. FATHER'S NAME First Middle Last<br>Morris Zola   |                                     | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Sadie Fell  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>No  |                                     | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT Brother<br>Joseph Zola - 11338 Cherry Hill  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BRAIN STEM COMPRESSION</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>intracerebral hemorrhage</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Ruptured intracranial aneurysm</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Saccular aneurysm</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>3 days</u><br><u>Congenital</u> |                                     |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>330X</u>  |                                     |   |  |   |  |
| 19a. DATE OF OPERATION   |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                    |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |                                     | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                         |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |                                     | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 30, 1968</u> , to <u>Oct 4, 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct 3, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |                                     |   |  |   |  |
| 22b. SIGNATURE<br><u>John Thomas Lord</u>  |                                     | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br><u>10/4/68</u>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>John Thomas Lord</u>  |                                     | 22e. ADDRESS<br><u>1015 Spring St Silver Spring Md.</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                     | 23b. DATE<br><u>10-9-68</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Arlington National Cem. Arlington, Virginia</u>                |  |
| 24. FUNERAL DIRECTOR<br><u>B. Danzansky &amp; Sons Washington, DC</u>  |                                     | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>OCT 10 1968</u>  |  |
|  |                                     |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |

1967

CHANDLER DEATH

1967



FOR COLLECTION

1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14668

14676

|   |  |   |   |   |  |   |  |  |  |   |  |
|---|--|---|---|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Heba J Kelleam</i>   |  |   | 2a. DATE OF DEATH<br>Month <i>10</i> Day <i>13</i> Year <i>68</i> |   |  | 2b. HOUR<br><i>3:30</i> AM  |  |  |  |   |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>   |   | 5. DATE OF BIRTH<br><i>6/8/01</i>   |  | 6. AGE (In years last birthday)<br><i>67</i> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <i>4</i> DAYS <i>4</i>   |  | IF UNDER 24 HRS.<br>HOURS <i>4</i> MIN.                       |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Miss.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Montgomery Co.</i> Md.   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring Md.</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Holy Cross Hosp.</i> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Rental Clerk</i>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Appt. Rentals</i>                                       |  |  |  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Md.</i>   |  | 13b. COUNTY<br><i>Montgomery</i>  |   | 13c. CITY OR TOWN<br><i>Silver Spring</i>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><i>11531 Lovejoy St.</i> |  |   |  |
| 14. FATHER'S NAME<br>First <i>Bulus</i> Middle <i>M.</i> Last <i>Parker</i>   |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Amanda</i> Middle <i>J.</i> Last <i>Nordin</i>                     |   |   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no or unknown <i>no</i> (If yes give war or dates of service) <i>--</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>yes</i>  |   | 17. INFORMANT<br>Name <i>Mrs. Elaine E. Finklea</i> Address <i>11531 Lovejoy St. Md.</i>  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonia lobar bilateral</i><br><i>481X</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>7 days</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>491X None</i>   |  |   |   |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><i>10/12/68</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Tracheotomy - Respiratory failed</i>             |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><i>yes</i>              |  |  |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br><i>19</i>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10/7</i> , 19 <i>68</i> , to <i>10/13</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>10/13</i> 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                |  |   |   |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Ralph F. Patten MD</i>   |  | 22c. DATE SIGNED<br><i>10/13/68</i>   |   | 22d. PHYSICIAN'S NAME (Type)<br><i>RALPH F. PATTEN MD</i>   |  |   |  |  |  |   |  |
| 22e. ADDRESS<br><i>1407 Modesto</i>   |  |   |   |   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  | 23b. DATE<br><i>10/16/68</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Llano Cemetery</i>   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Ana rillo, Texas</i>                        |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><i>J. Lee Hulse</i>   |  | 24a. REC'D BY REGISTRAR<br><i>Warner E. Pumphrey, Inc.</i>  |   | 24b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  | 25a. OCT 16 1968  |  |  |  |   |  |

11078

11078

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11078

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pertinent items 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |  |  |  |   |   |  |   |  |
|---|---------|--|--|--|---|---|--|---|--|
| <div>14669</div> <div>14677</div>   |         |  |  |  |   |   |  |   |  |
| 1. DECEASED-NAME<br>(Type or Print)   |         |  | First Middle Last  |  |   | 2a. DATE KNOWN OF DEATH   |  |   | 2b. HOUR                                     |
| OLIVER STEWART KERN   |         |  |  |  |   | <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year<br><input type="checkbox"/> 10-11 1968 |  |   | 4:15p  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS<br>HOURS MIN.   |  | 2c. DATE PRONOUNCED DEAD                    |  |
| Male  | White   | 12-5-86  | 81 YRS.  |  |   |   |  | Month 10 Day 11 Year 1968<br>2d. HOUR 4:15p |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |   |  |
| New York  |         | U.S.A.   |  |  |   | Montgomery Md.  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |   | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Takoma Park   |         |  | Wash. San. & Hosp.   |  |   | Engineer  |  |   | Electrical                                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER                      |  |
| Md.   |         |  | Mont.  |  | Rockville   |   |  | 717 Maple Ave.                              |  |
| 14. FATHER'S NAME First Middle Last   |         |  | 15. MOTHER'S MAIDEN NAME First Middle Last                                   |  |   |   |  |   |  |
| Unknown   |         |  | Unknown  |  |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |   |  |   |  |
| Yes   |         |  | 152-09-0220A   |  | Grandson Mr. Allen Kern, 717 Maple Ave., Rockville, Md.                         |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>coronary occlusion, acute -</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Arterio Sclerosis Generalized -</u>  |         |  |  |  |   |   |  |   | 5 hr.<br>5 hr.<br>years.                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |         |  |  |  |   |   |  |   |  |
| 4201  |         |  |  |  |   |   |  |   |  |
| 19a. DATE OF OPERATION  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |   |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |  | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.                          |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |   |  |   |  |
|   |         |  | 19   |  |   |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |  | 21f. LOCATION Street or R.F.D. No.  |   | City or Town   |   | County State                                 |
|   |         |  |  |  |   |   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |  |  |   |   |  |   |  |
| ACTUAL SIGNATURE  |         |  | John G. Ball   |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   | 22b. DATE SIGNED                             |
| EXAMINER'S NAME (Type)  |         |  | John G. Ball   |  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   | OCT-11, 1968.                                |
|   |         |  |  |  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  |
|   |         |  |  |  |   | ADDRESS (Street, city, town, or county)   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |  |   |  |
| Burial  |         | 10-15-1968   |  | Rock Creek Cemetery  |   | Washington, D. C.   |  |   |  |
| Funeral Director C. Glen Carter   |         |  |  | ADDRESS  |   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                  |  |
| Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S. Md.   |         |  |  |  |   | DATE OCT 21 1968  |  | J. Charles Judge                            |  |

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

|  |  |                      |  |   |  |   |  |  |                                      |  |  |  |  |  |  |
|--|--|----------------------|--|---|--|---|--|--|--------------------------------------|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>Herbert Sam Kidd</b>  |  |                      | First Middle Last                        |   |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>10</b> Day <b>23</b> Year <b>1968</b>  |  |  | 2b. HOUR <b>8:10 A</b>               |  |  |  |  |  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b> |  | 5. DATE OF BIRTH <b>10-18-10</b>  |  | 6. AGE (In years last birthday) <b>58</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |                                      | IF UNDER 24 HRS<br>HOURS MIN.                  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Ala</b>   |  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>Amer</b> |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH <b>Montgomery</b> |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Takoma Park</b>   |  |                      |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash San &amp; Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>plumber</b> |                                      |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Montgomery</b>   |  |                      |  |   |  | 13c. CITY OR TOWN <b>Silver Spring</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                      |                                      | 13e. STREET AND NUMBER <b>9115 Bradford Rd</b> |  |  |  |  |  |
| 14. FATHER'S NAME <b>Zachariah Kidd</b>  |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME  |  |  |                                      |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>  |  |                      |  |   |  | 16b. SOCIAL SECURITY NO. <b>579 03 9607</b>   |  | 17. INFORMANT <b>Hosp record</b>   |                                      |  |  | ADDRESS  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute pulmonary emboli</b><br><b>450 X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>accompanied by pneumonitis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |  |                      |  |   |  |   |  |  |                                      |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>465 X</b>   |  |                      |  |   |  |   |  |  |                                      |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                      |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |                                      |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  |                      |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>19</b>  |  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                        |                                      |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                |  |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                                      |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above held on death resulted from: Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion<br>Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                      |  |   |  |   |  |  |                                      |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Belden R. Keap</b>   |  |                      |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  | 22b. DATE SIGNED <b>10/23/1963</b>   |                                      |  |  |  |  |  |  |
| EXAMINER'S NAME (Type) <b>BELDEN R. KEAP, M.D.</b>   |  |                      |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  | ADDRESS <b>Baltimore</b> (City or Town) (County) (State)   |                                      |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>   |  |                      |  | 23b. DATE <b>Oct. 25, 1968</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>   |                                      |  |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md</b>                |  |  |  |
| 24. FUNERAL DIRECTOR <b>J. Arthur Walters</b>  |  |                      |  |   |  | ADDRESS <b>254 Carroll St NW. DC</b>  |  |  |                                      |  |  | 25a. REC'D BY REGISTRAR <b>OCT 28 1968</b>                                       |  | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b> |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| 14671   |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  | 14679             |  |                  |  |  |  |
|---|--|--|--|--|--|--|--|-------------------|--|------------------|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  | First Middle Last  |  |  |  | 2a. DATE OF DEATH |  |                  |  | 2b. HOUR                                     |  |
| JOHANNA   |  |  |  | KILSHEIMER   |  |  |  | Month Day Year    |  | 3:50 PM          |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)                                      |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS. |  |  |  |
| FEMALE  |  | WHITE  |  | 8-10-04  |  | 64 YRS.  |  | MONTHS DAYS       |  | HOURS MIN.       |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH   |  |                   |  |                  |  |  |  |
| GERMANY   |  | U.S.A.   |  |  |  | MONTGOMERY   |  |                   |  |                  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |                   |  |                  |  |  |  |
| BETHESDA  |  | SUBURBAN   |  | HARPER HILL  |  |  |  |                   |  |                  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE  |  | 13b. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET AND NUMBER   |  |                   |  |                  |  |  |  |
| DISTRICT OF COLUMBIA  |  |  |  |  |  | 3809 WARREN ST. N.W.   |  |                   |  |                  |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |  |  |                   |  |                  |  |  |  |
| First Middle Last   |  | First Middle Last  |  |  |  |  |  |                   |  |                  |  |  |  |
| Julius Benjamin   |  | EMELIE LOEB  |  |  |  |  |  |                   |  |                  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | Address  |  |                   |  |                  |  |  |  |
|   |  |  |  | ALYN E. KILSHEIMER - 271 CONN AVE N.W.   |  | WASH., D.C.  |  |                   |  |                  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |  |  |                   |  |                  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |  |  |                   |  |                  |  |  |  |
| IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u>   |  |  |  |  |  |  |  |                   |  |                  |  |  |  |
| 4129 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |  |  |                   |  |                  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4221</u>  |  |  |  |  |  |  |  |                   |  |                  |  |  |  |
| (b) <u>Arteriosclerotic Cardiovascular Disease</u>  |  |  |  |  |  |  |  |                   |  |                  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |  |  |                   |  |                  |  |  |  |
| (c)   |  |  |  |  |  |  |  |                   |  |                  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |  |  |                   |  |                  |  |  |  |
| <u>Carcinoma of Left Kidney, Post op with Metastatic Disease. (Benign)</u>  |  |  |  |  |  |  |  |                   |  |                  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                   |  |                  |  |  |  |
| None  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |                   |  |                  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |                   |  |                  |  |  |  |
| HOUR A.M. Month Day Year  |  | P.M.   |  |  |  |  |  |                   |  |                  |  |  |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |  | Street or R.F.D. No.   |  | City or Town      |  | County           |  | State  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |                   |  |                  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 3, 1968</u> , to <u>Oct 4, 1968</u> , that (I) (we) last saw the deceased alive on <u>Oct 4, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |                   |  |                  |  |  |  |
| 22b. SIGNATURE  |  | 22c. DATE SIGNED   |  | 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS   |  |                   |  |                  |  |  |  |
| Richard H. Edenbaum MD  |  | 10/5/68  |  | Richard H. Edenbaum MD   |  | 4700 Bradley Boulevard Ch. Ch. Md.                                   |  |                   |  |                  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town)   |  | (County)          |  | (State)          |  |  |  |
|   |  | 10/6/68  |  | Mt. Lebanon Cem.   |  | Hyattsville Md.  |  |                   |  |                  |  |  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                   |  |                  |  |  |  |
| B. Dargowsky & Sons, 750 14th St N.W. WASH. D.C.  |  | DATE   |  | OCT 8 1968   |  | J. Charles Judge   |  |                   |  |                  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Cleared by medical examiner Dr. John Ball

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14680

|   |  |  |      |  |  |  |                                   |
|---|--|--|------|--|--|--|-----------------------------------|
| 1. DECEASED-NAME (Type or print) <i>Mildred First xxxxxxxx</i>  |  | Middle <i>S.</i>   | Lost | 2a. DATE OF DEATH<br>Month <i>10</i> Day <i>12</i> Year <i>1968</i>  |  |  | 2b. HOURS <i>10A</i> MIN <i>M</i> |
| 3. SEX <i>Female</i>  |  | 4. RACE <i>Caucasian</i>   |      | 5. DATE OF BIRTH<br><i>12-19-1884</i>  |  | 6. AGE (In years last birthday) <i>83</i> YRS.   |                                   |
| 7a. BIRTHPLACE (State or foreign country) <i>New Hampshire U.S.A.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?   |      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <i>Montgomery</i> Md.   |                                   |
| 10. CITY OR TOWN OF DEATH <i>Jakoma Park</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wash. Hosp. &amp; Hosp. San. &amp; Hosp.</i> |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>  |                                   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>  |  | 13b. COUNTY <i>Pr. Georges</i>   |      | 13c. CITY OR TOWN <i>Adelphi</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   |
| 14. FATHER'S NAME First <i>Walter</i> Middle <i>D.</i> Last <i>Stevens</i>  |  | 15. MOTHER'S MAIDEN NAME First <i>Martha</i> Middle <i>G.</i> Last <i>Shute</i>  |      | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)  |  |  |                                   |
| 16b. SOCIAL SECURITY NO. <i>220-444-6928</i>  |  | 17. INFORMANT Address <i>Adelphi, Md.</i> <i>Donald Kimball 2503 Woodberry Street</i>  |      |  |  |  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>acute shock -</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>acute pancreatitis -</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>marked anemia -</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <i>28771</i><br><i>296X</i><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i><br><i>1+ days</i><br><i>2+ hrs.</i> |  |  |      |  |  |  |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Thrombocytopenic purpura &amp; multiple hematomas.</i>   |  |  |      |  |  |  |                                   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |      | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>              |                                   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR UNDERLYING CAUSE OF DEATH <input checked="" type="checkbox"/> (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR <i>A.M.</i> Month <i>10</i> Day <i>19</i> P.M.  |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |                                   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)  |      | 21f. LOCATION <i>Street</i> or R.F.D. No. City or Town County State  |  |  |                                   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3 Oct</i> , 19 <i>67</i> , to <i>12 Oct</i> , 19 <i>68</i> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <i>11 Oct</i> , 19 <i>68</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>viewed</i> (did not) view the body after death.   |  |  |      |  |  |  |                                   |
| 22b. SIGNATURE <i>M. H. Richwine M.D.</i>   |  | 22c. PHYSICIAN'S NAME (Type) <i>M. H. RICHWINE M.D.</i>  |      | 22d. ADDRESS <i>5522 WESTERN AVE CHEVY CHASE, Md.</i>  |  | 22e. DATE SIGNED <i>13 Oct 68</i>  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE <i>10-16-1968</i>  |      | 23c. NAME OF CEMETERY OR CREMATORY <i>St. Lincoln Cemetery</i>   |  | 23d. LOCATION (City or Town) (County) (State) <i>Prince Georges Maryland</i>                 |                                   |
| 24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>  |  | 25a. REC'D BY REGISTRAR <i>C. Glen Carter</i>  |      | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>  |  | DATE <i>OCT 21 1968</i>  |                                   |



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CERTIFICATE OF DEATH

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                     |   |   |   |   |  |   |   |                         |
|---|---------------------|---|---|---|---|--|---|---|-------------------------|
| 1. DECEASED-NAME<br>(Type or Print) <i>Narothy E. Kline</i>   |                     |   | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input type="checkbox"/> MONTH DAY YEAR<br>MATED <input type="checkbox"/> 10/12 1968 |   |   | 2b. HOUR<br>30<br>10 PM  |   |   |                         |
| 3. SEX<br><i>FEMALE</i>   | 4. RACE<br><i>W</i> | 5. DATE OF BIRTH<br><i>Feb. 9-1926</i>  | 6. AGE (In years last birthday)<br><i>42</i>  | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN.                    | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><i>10 12 1968</i>                      |   |   | 2d. HOUR<br>30<br>10 PM |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Montgomery</i> Md.  |   |   |                         |
| 10. CITY OR TOWN OF DEATH<br><i>Bethesda</i>  |                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Suburban</i> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Housewife</i>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |                         |
| 13a. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission), STATE<br><i>Maryland</i>   |                     | 13b. COUNTY<br><i>Montgomery</i>  |   | 13c. CITY OR TOWN<br><i>Bethesda</i>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER<br><i>5518 Frederick Ave</i>   |                         |
| 14. FATHER'S NAME<br>First Middle Last<br><i>Harry P. Shelling</i>  |                     |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><i>Bessie Mae Fogel</i>  |   |   |  |   |   |                         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <i>No</i>   |                     |   | 16b. SOCIAL SECURITY NO.<br><i>213-24942</i>  |   | 17. INFORMANT<br><i>William Glen Fudick, M.D.</i> |  | ADDRESS<br><i>120 W-5-H St.</i>   |   |                         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Aneurysm, basillar (congenital, Berry type) ruptured</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4309</i><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>48 hr.</i> |                     |   |   |   |   |  |   |   |                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>330x</i>   |                     |   |   |   |   |  |   |   |                         |
| 19a. DATE OF OPERATION  |                     |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |                         |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                     | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <i>19</i>                                |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |   |                         |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                     | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                    |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |   |   |                         |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>              |                     |   |   |   |   |  |   |   |                         |
| ACTUAL SIGNATURE<br><i>John G. Ball</i>   |                     |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   | 22b. DATE SIGNED<br><i>Oct 14, 1968</i>  |   |   |                         |
| EXAMINER'S NAME (Type) <i>Dr. John G. Ball</i>  |                     |   | M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |   | ADDRESS (Street, city, town, or county) <i>Montgomery Co. Md.</i>                    |   |   |                         |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                     | 23b. DATE<br><i>10-17-1968</i>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Resthaven Memorial Gardens</i>   |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Frederick, Frederick, Md.</i>    |   |   |                         |
| 24. FUNERAL DIRECTOR<br><i>Robert E. Dailey &amp; Son</i>   |                     |   |   | ADDRESS<br><i>Frederick, Maryland</i>   |   | 25a. REC'D BY REGISTRAR<br>DATE<br><i>OCT 16 1968</i>                                |   | 25b. REGISTRAR'S SIGNATURE<br><i>J. Charles Judge</i> |                         |

85022

This micrograph shows a single cell with a large, dark, centrally located nucleus. Within the nucleus, a smaller, denser nucleolus is visible. The surrounding cytoplasm is lighter and less distinct.

1 202. 2 1/2

(continued)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~pages 1 and 2~~ should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 14674   |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                                    |                           |   |                             | 14682   |  |  |  |
|---|--|--|---------------------------|---|-----------------------------|---|--|--|--|
| CERTIFICATE OF DEATH  |  |  |                           |   |                             |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <b>Caroline</b>   |  |  | First <b>T.</b>           |   | Middle <b>Knickerbocker</b> |   | Last   |  |  |
| 2. DATE OF DEATH<br><b>10</b> Month <b>1</b> Day <b>1968</b>  |  |  | 2b. HOUR<br><b>5:10</b> M |   |                             |   |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |                           | 5. DATE OF BIRTH<br><b>10/31/1877</b>   |                             | 6. AGE (In years last birthday)<br><b>90</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maine</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                           | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                             | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Kensington</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Kensington Nursing Home</b> |                           | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>   |                             | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Mont.</b>  |                           | 13c. CITY OR TOWN<br><b>Bethesda</b>  |                             | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>5016 Hampden Lane</b>                               |  |
| 14. FATHER'S NAME<br><b>Orlando</b>   |  |  | First <b>Thayer</b>       |   | Last                        |   | 15. MOTHER'S MAIDEN NAME<br><b>Elizabeth M. Marble</b> |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or <del>both</del> (If yes give war or dates of service)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>005-09-8961</b>   |                           | 17. INFORMANT<br><b>Daughter</b>  |                             | Address<br><b>Mrs. C.R. Harley Same as Item 13.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>402X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Hypertensive heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>443X</b> |  |  |                           |   |                             |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 min</b><br><b>10 years</b> |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                           | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                             | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |                           | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                             |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |                           | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                             |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>64</b> , to <b>1 Oct</b> , 19 <b>68</b> , that (I) (we) lost the deceased alive on <b>24 Sept</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |                           |   |                             |   |  |  |  |
| 22b. SIGNATURE<br><b>Herbert Martyn Jr MD</b>   |  |  |                           | 22c. DATE SIGNED<br><b>1 Oct 68</b>   |                             | 22d. PHYSICIAN'S NAME (Type)<br><b>HERBERT MARTYN JR</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE<br><b>10- 6-68</b>   |                           | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Paris Hill Cemetery</b>  |                             | 23d. LOCATION (City or Town) (County) (State)<br><b>Paris, Maine</b>                            |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>   |  |  |                           | 25a. REC'D BY REGISTRAR<br><b>OCT 7 1968</b>  |                             | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |

| Name            | Age | Sex    | Date of Death | Place of Death |
|-----------------|-----|--------|---------------|----------------|
| John Doe        | 45  | Male   | Jan 15 1888   | New York       |
| Jane Smith      | 32  | Female | Feb 20 1888   | New York       |
| Robert Johnson  | 28  | Male   | Mar 10 1888   | New York       |
| Mary White      | 60  | Female | Apr 5 1888    | New York       |
| William Brown   | 18  | Male   | May 1 1888    | New York       |
| Elizabeth Green | 75  | Female | Jun 15 1888   | New York       |
| Thomas Black    | 55  | Male   | Jul 10 1888   | New York       |
| Sarah Miller    | 40  | Female | Aug 5 1888    | New York       |
| James Wilson    | 30  | Male   | Sep 1 1888    | New York       |
| Anna Taylor     | 25  | Female | Oct 15 1888   | New York       |
| George Evans    | 65  | Male   | Nov 10 1888   | New York       |
| Charlotte King  | 50  | Female | Dec 5 1888    | New York       |
| Henry Lee       | 40  | Male   | Jan 1 1889    | New York       |
| Margaret Hall   | 35  | Female | Feb 15 1889   | New York       |
| Charles Adams   | 20  | Male   | Mar 10 1889   | New York       |
| Elizabeth Clark | 70  | Female | Apr 5 1889    | New York       |
| John Davis      | 55  | Male   | May 1 1889    | New York       |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |                                  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--------------------------------------|--|--|--|--|----------------------------------|--|--|--|--|
| 14675  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |  |  | 14683  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |                                  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) First Middle Last<br>WILLIAM C. LANGE   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH<br>Oct. 17 1968   |  |  |  |  |   |  |  |  |  | 2b. HOUR<br>8:45 PM  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |                                  |  |  |  |  |
| 3. SEX<br>male   |  |  |  |  | 4. RACE<br>white   |  |  |  |  | 5. DATE OF BIRTH<br>April 17, 1885  |  |  |  |  | 6. AGE (In years last birthday)<br>83 YRS.  |  |  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN                             |  |  |  |  | IF UNDER 24 HRS.                               |  |  |  |  |                                      |  |  |  |  |                                  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>OHIO  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH<br>Montgomery Md.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |                                  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Buckeye   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Dixmore Valley N. N. |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>AUDITOR  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>PRIV. IND.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |                                  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MD.   |  |  |  |  | 13b. COUNTY<br>MONTG.  |  |  |  |  | 13c. CITY OR TOWN<br>BETHESDA   |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  | 13e. STREET AND NUMBER<br>5008 EARLSTON DR.                          |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |                                  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Friedrich   |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Emma Barz  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |                                  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)<br>No   |  |  |  |  | 16b. SOCIAL SECURITY NO.<br>578 24 5197  |  |  |  |  | 17. INFORMANT<br>DR. G. ROBT. LANGE-SON-SAME AS #13   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |                                  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4409 Pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  |  |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 years<br>3 days                               |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |                                  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>4500   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |                                  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |   |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |                                  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |                                  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                         |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |                                  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/25, 1967, to 10/17, 1968, that (I) (we) last saw the deceased alive on 10/15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                      |  |  |  |  |  |  |  |  |  |   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |                                  |  |  |  |  |
| 22b. SIGNATURE<br>Harry N. Carlton MD  |  |  |  |  |  |  |  |  |  |   |  |  |  |  | DEGREE<br>MD  |  |  |  |  | ATTENDING PHYS.<br><input checked="" type="checkbox"/>               |  |  |  |  | MED. DIRECTOR <input type="checkbox"/>         |  |  |  |  | STAFF PHYS. <input type="checkbox"/> |  |  |  |  | 22c. DATE SIGNED<br>Oct 17, 1968 |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>HARRY N. CARLTON   |  |  |  |  |  |  |  |  |  |   |  |  |  |  | 22e. ADDRESS<br>8811 Colesville Rd, Silver Spring Md  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |                                  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>CREMATION   |  |  |  |  | 23b. DATE<br>10/19/68  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CEDAR HILL CREMATORY  |  |  |  |  |   |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>SUITLAND, MD.       |  |  |  |  |  |  |  |  |  |                                      |  |  |  |  |                                  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>JOS. GAWLER'S SONS, 5130 WIS. AVE, WASH., D.C.   |  |  |  |  |  |  |  |  |  |   |  |  |  |  | ADDRESS   |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE OCT 23 1968                          |  |  |  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. Jager |  |  |  |  |                                      |  |  |  |  |                                  |  |  |  |  |



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UNCLASSIFIED



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10M-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14676

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14684

|  |                   |  |  |   |   |  |  |
|--|-------------------|--|--|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>Charles Ralph</b>   |                   | Last <b>Langley</b>  |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <b>Oct 3</b> Year <b>1968</b>                                |   | 2b. HOUR <b>PM</b>   |  |
| 3. SEX <b>M.</b>   | 4. RACE <b>W.</b> | 5. DATE OF BIRTH <b>3/7/1903</b>   | 6. AGE (In years last birthday) <b>65</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>6</b> DAYS <b>5</b>  | IF UNDER 24 HRS.<br>HOURS <b>12</b> MIN <b>45</b> | 2c. DATE PRONOUNCED DEAD<br>Month <b>Oct.</b> Day <b>4.</b> Year <b>1968</b>                 |  |
| 7a. BIRTHPLACE (State or foreign country) <b>Wash. D.C.</b>  |                   | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH <b>Montgomery</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>   |                   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>816 Easley St.</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Ship Analyst-Retired</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>US Gov't.</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>   |                   | 13b. COUNTY <b>Montgomery</b>  |  | 13c. CITY OR TOWN <b>Silver Spring</b>  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME First <b>Clarence</b> Middle <b>A.</b> Last <b>Langley</b>   |                   | 15. MOTHER'S MAIDEN NAME First <b>Carrie</b> Middle <b>Jane</b> Last <b>Downs</b>                  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |                   | 16b. SOCIAL SECURITY NO. <b>217-42-4713</b>  |  | 17. INFORMANT <b>Silver Spring, Md. Marguerite Langley 611 Ray Drive</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>5321 Hemorrhage. Gastrointestinal-Severe</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>Rupture of Duodenal Ulcer.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Chronic Alcoholism</b>                           |                   |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min.</b>                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>5411</b>   |                   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |                   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                   | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>19</b> P.M.                                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK   |                   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                       |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                   |  |  |   |   |  |  |
| ACTUAL SIGNATURE <b>John G. Ball</b>   |                   | M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | 22b. DATE SIGNED <b>Oct 4, 1968</b>  |  |
| EXAMINER'S NAME (Type) <b>John G. Ball</b>   |                   |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   | ADDRESS (Street, city, town, or county) <b>Bethesda, Md.</b>                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                   | 23b. DATE <b>Oct 7, 1968</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>St. Lincoln Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State) <b>Prince George County, Md.</b>               |  |
| 24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc. 8434 Ga. Ave. S. S. Md.</b>   |                   |  |  | 25a. REC'D BY REGISTRAR <b>OCT 10 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14677

CERTIFICATE OF DEATH

14685

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><i>Miss Elizabeth Darymple Hanning</i>   |  |   | 2a. DATE OF DEATH<br>Month <i>10</i> Day <i>8</i> Year <i>1968</i>  |  | 2b. HOUR<br><i>10:36</i> M                            |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>White</i>  | 5. DATE OF BIRTH<br><i>12-30-1886</i>   |   | 6. AGE (In years last birthday)<br><i>81</i> YRS.                                | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>HOURS<br>MIN.    |
| 7a. BIRTHPLACE (State or foreign country)<br><i>New Jersey</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><i>Montgomery County Md.</i>  |  |   |
| 10. CITY OR TOWN OF DEATH<br><i>Takoma Park</i>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Washington Sand Hosp.</i> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><i>Government worker</i>                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>U.S. govt</i> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br><i>Maryland</i>  | 13b. COUNTY<br><i>Montgomery</i>   | 13c. CITY OR TOWN<br><i>Wheaton</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13e. STREET AND NUMBER<br><i>2504 Henderson St.</i>                              |   |
| 14. FATHER'S NAME First Middle Last<br><i>Charles W. Hanning</i>  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>Belle Darymple</i>   |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or (unknown)  |  | 16b. SOCIAL SECURITY NO.<br><i>no</i>   |   | 17. INFORMANT <i>Margaret C. Lanning</i> Address <i>2504 Henderson St.</i>       |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> 3 days<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>congestive heart failure</i> 3 weeks<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><i>4341 diabetes + generalized atherosclerosis</i>   |  |   |   |  |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?             |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>8/1/68</i> , 19__, to <i>10/8/68</i> , 19__ that (I) (we) last saw the deceased alive on <i>10/7/68</i> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |  |   |
| 22b. SIGNATURE<br><i>Patrick C. Jamison</i>   |  |   | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED<br><i>10/8/68</i>   |   |
| 22d. PHYSICIAN'S NAME (Type)<br><i>Patrick C. Jamison</i>   |  |   | 22e. ADDRESS<br><i>11718 Georgea Silver Spring</i>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  | 23b. DATE<br><i>10-10-1968</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Cedar Hill Cemetery</i>  |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Prince Georges, Maryland</i> |   |
| 24. FUNERAL DIRECTOR<br><i>Warner E. Pumphrey, Inc.</i>   |  | ADDRESS<br><i>8434 Ga. Avenue</i>   |   | 25a. REC'D BY REGISTRAR<br><i>OCT 11 1968</i>                                    | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>    |

14683

INSTRUCTIONS TO THE JURY

THE STATE OF TEXAS

VS

THE PEOPLE OF THE STATE OF TEXAS

VS

THE STATE OF TEXAS

VS

THE STATE OF TEXAS

VS

THE STATE OF TEXAS

VS

THE STATE OF TEXAS

VS

THE STATE OF TEXAS

VS

THE STATE OF TEXAS

VS

THE STATE OF TEXAS

VS

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                         |                          |  |                       |  |                      |   |   | 14686   |                         |   |  |                         |  |
|---|--|-------------------------|--------------------------|--|-----------------------|--|----------------------|---|---|---|-------------------------|---|--|-------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                         |                          |  |                       |  |                      |   |   |   |                         |   |  |                         |  |
| 1. DECEASED-NAME<br>(Type or Print)   |  |                         | First<br><i>Theodore</i> |  | Middle<br><i>Paul</i> |  | Last<br><i>Lantz</i> |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>Oct</i> Day <i>12</i> Year <i>1968</i> |   | 2b. HOUR <i>6:05</i> AM |   |  |                         |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>White</i> |                          | 5. DATE OF BIRTH<br><i>Jan. 2, 1879</i>  |                       | 6. AGE (In years last birthday)<br><i>89</i> YRS                   |                      | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____  |   | IF UNDER 24 HRS<br>HOURS _____ MIN. _____                                     |                         | 2c. DATE PRONOUNCED DEAD<br>Month <i>October</i> Day <i>14</i> Year <i>1968</i>               |  | 2d. HOUR <i>6:05</i> AM |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Akron Ohio</i>  |  |                         |                          | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |                       |  |                      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><i>Montgomery</i>                                       |                         |   |  |                         |  |
| 10. CITY OR TOWN OF DEATH<br><i>Kensington</i>  |  |                         |                          | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Kensington Gardens San.</i> |                       |  |                      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)<br><i>Retired</i>  |   |   |                         | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Goodrich Rubber, Co.</i>                              |  |                         |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>   |  |                         |                          | 13b. CITY OR TOWN<br><i>Montgomery</i>   |                       | 13c. CITY OR TOWN<br><i>Takoma Park</i>                            |                      | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET AND NUMBER<br><i>7403 Cedar Ave.</i>                              |                         |   |  |                         |  |
| 14. FATHER'S NAME<br>First <i>William</i> Middle _____ Last <i>Lantz</i>  |  |                         |                          | 15. MOTHER'S MAIDEN NAME<br>First <i>Henrietta</i> Middle _____ Last <i>Sherbondy</i>                          |                       |  |                      |   |   |   |                         |   |  |                         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><i>no</i>   |  |                         |                          | 16b. SOCIAL SECURITY NO.<br><i>299-01-1857-A</i>   |                       | 17. INFORMANT <i>7403 Cedar Ave. Wm. H. Gmp Takoma Park, Md.</i>   |                      |   |   |   |                         |   |  |                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary Insufficiency Acute</i><br><i>4129</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Cardio Vascular Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Generalized Atherosclerosis</i>   |  |                         |                          |  |                       |  |                      |   |   |   |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Sudden</i><br><i>Years</i><br><i>Years</i> |  |                         |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>7201</i>   |  |                         |                          |  |                       |  |                      |   |   |   |                         |   |  |                         |  |
| 19a. DATE OF OPERATION  |  |                         |                          | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |                       |  |                      |   |   |   |                         | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |                         |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  |                         |                          | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. _____ P.M. <i>19</i>   |                       |  |                      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |                         |   |  |                         |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                         |                          | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                   |                       |  |                      | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____  |   |   |                         |   |  |                         |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |                         |                          |  |                       |  |                      |   |   |   |                         |   |  |                         |  |
| ACTUAL SIGNATURE<br><i>John S. Ball</i>   |  |                         |                          | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                       |  |                      | 22b. DATE SIGNED<br><i>Oct. 14, 1968</i>  |   |   |                         |   |  |                         |  |
| EXAMINER'S NAME (Type)  |  |                         |                          | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                       |  |                      | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   |                         |   |  |                         |  |
|   |  |                         |                          | ADDRESS (Street, city, town, or county)  |                       |  |                      |   |   |   |                         |   |  |                         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |  |                         |                          | 23b. DATE<br><i>Oct. 17, 1968</i>  |                       | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Oakwood Memorial Park</i> |                      |   |   | 23d. LOCATION (City or Town) (County) (State)<br><i>Chatworth, California</i> |                         |   |  |                         |  |
| 24. FUNERAL DIRECTOR<br><i>Warner E. Pumphrey, Inc.</i>   |  |                         |                          | ADDRESS<br><i>8434 Ga. Ave. Sil. Spg.</i>  |                       |  |                      | 25a. REC'D BY REGISTRAR<br>DATE <i>OCT 21 1968</i>  |   |   |                         | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |                         |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 13 (11-68)  
30M REV 11-68

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| 14679  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 14687  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) <i>Frederic P Lee</i>   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH <i>Oct. 2 1968</i>   |  |  |  |  |  |  |  |  |  | 2b. HOUR <i>11:15 M</i>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 3. SEX <i>m</i>  |  |  |  |  |  |  |  |  |  | 4. RACE <i>w</i>   |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH <i>1/6/1937</i>   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday) <i>75</i> YRS.                          |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS                                       |  |  |  |  |  |  |  |  |  | IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <i>Nebraska</i>  |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>             |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH <i>Montgomery</i> Md.                                |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i>  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban Hospital</i>                                  |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Chapel</i>   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                       |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> COUNTY <i>Montgomery</i>   |  |  |  |  |  |  |  |  |  | 13b. CITY OR TOWN <i>Bethesda</i>  |  |  |  |  |  |  |  |  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 13d. STREET AND NUMBER <i>740 Glenbrook Road</i>                        |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First <i>George</i> Middle <i>Lee</i> Last   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First <i>Maudie</i> Middle <i>Paddock</i> Last  |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give year or dates of service) <i>Army</i> |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. <i>401-09-0523</i>                             |  |  |  |  |  |  |  |  |  | 17. INFORMANT <i>Mrs. Marion Lee</i> Address <i>same as above</i> |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute myocardial infarct</i><br>4109 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Coronary arterial sclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br>4201   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?    |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1958</i> , to <i>October 2, 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept. 26</i> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <i>Alban W. Eger</i>  |  |  |  |  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED <i>Oct. 2, 1968</i>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <i>Alban W. Eger, M.D.</i>  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS <i>1301 Eye street, N.W., Washington, D.C.</i>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>   |  |  |  |  |  |  |  |  |  | 23b. DATE <i>10-4-68</i>   |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) <i>Suitland, Maryland</i> |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  |  |  |  |  |  | ADDRESS  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>                         |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |
| ROBERT A. PUMPHREY, Bethesda, Maryland   |  |  |  |  |  |  |  |  |  | DATE OCT 7 1968  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |                             |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| 14680   |  |  |   |  |  |   |  |  |   | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |  |                                |  |  |  |  | 14688      |  |  |  |  |  |  |  |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|--------------------------------|--|--|--|--|------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |  |   |  |  |   |  |  |   | 2a. DATE OF DEATH  |  |   |  |  |                                |  |  |  |  | 2b. HOUR A |  |  |  |  |  |  |  |  |  |
| First Middle Last<br>Homer David Liebersohn   |  |  |   |  |  |   |  |  |   | Month Day Year<br>October 7 1968   |  |   |  |  |                                |  |  |  |  | 5:30 M     |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Male  |  |  | 4. RACE<br>White  |  |  | 5. DATE OF BIRTH<br>June 12, 1913   |  |  | 6. AGE (in years<br>last birthday)<br>55 YRS.   |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                  |  |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |  |  |  |            |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Pennsylvania  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>Montgomery  |  |  | Md.   |  |  |                                |  |  |  |  |            |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>The Clinical Center, NIH |  |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>Store Keeper  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY<br>Self-Employed   |  |  |   |  |  |                                |  |  |  |  |            |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>addressed) STATE<br>Maryland  |  |  | 13b. COUNTY<br>Montgomery   |  |  | 13c. CITY OR TOWN<br>Chevy Chase  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br>3231 Coquelin Terrace |  |  |                                |  |  |  |  |            |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Joseph Liebersohn   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Yetta Margolis   |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |  |  |            |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>579-24-6898   |  |  | 17. INFORMANT<br>The Medical Record Address<br>The Clinical Center, Bethesda, Md. 20014   |  |  |   |  |  |   |  |  |                                |  |  |  |  |            |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma of Liver (Widespread)</u><br>197.7<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |  |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>2 Years   |  |   |  |  |                                |  |  |  |  |            |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>1561   |  |  |   |  |  |   |  |  |   |  |  |   |  |  |                                |  |  |  |  |            |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?<br>Yes                  |  |  |   |  |  |                                |  |  |  |  |            |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |   |  |  |                                |  |  |  |  |            |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                             |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |   |  |  |                                |  |  |  |  |            |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>October 5</u> , 19 <u>68</u> , to <u>October 7</u> , 19 <u>68</u> , that (H) (we) last<br>saw the deceased alive on <u>October 7</u> , 19 <u>68</u> , and that in (H) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (X) (we) (did) (did not) view the body after death.    |  |  |   |  |  |   |  |  |   | 22b. SIGNATURE<br><u>Robert E. Curran MD</u><br>DEGREE ATTENDING PHYS. <input type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  |   |  |  |                                |  |  |  |  |            |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Robert E. Curran, MD.  |  |  | 22e. ADDRESS<br>The Clinical Center, National<br>Institutes of Health, Bethesda, Md.                        |  |  | 22c. DATE SIGNED<br>7 October 1968  |  |  |   |  |  |   |  |  |                                |  |  |  |  |            |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>10-9-1968  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>National Memorial Park  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Falls Church Va.                               |  |  |   |  |  |                                |  |  |  |  |            |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><u>Charles Judge &amp; Son 4217 9th St. N.W.</u>   |  |  | 25a. REC'D BY REGISTRAR<br>DATE<br>OCT 9 1968   |  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |   |  |  |   |  |  |                                |  |  |  |  |            |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14681

14689

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Michael Dennis LIGINO</b>   |   |   | 2a. DATE OF DEATH<br>Month <b>OCTOBER</b> Day <b>17</b> Year <b>68</b>                          |  | 2b. HOUR<br><b>620P</b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br><b>Jan. 27, 1945</b>  |   | 6. AGE (In years last birthday)<br><b>23</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>IF UNDER 24 HRS.<br>HOURS<br>MIN.             |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Illinois</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Naval Hospital</b> | 12a. USUAL OCCUPATION (Kind of work done during last working life, even if retired.)<br><b>U. S. Navy</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Illinois</b>   | 13b. COUNTY<br><b>Moline</b>  | 13c. CITY OR TOWN<br><b>Moline</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br><b>1349 19th Street</b>                                    |  |
| 14. FATHER'S NAME First Middle Last<br><b>Michael Ligino</b>   |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Mary Ellen Kovulchuck</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no or unknown) <b>yes</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>1964-1968 UNKNOWN</b>  |   | 17. INFORMANT Address<br><b>Mr. Michael Ligino, 1349 19th St. Moline, Ill.</b>       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>EMBRYONAL CARCINOMA OF THE TESTES WITH WIDE SPREAD METASTASIS.</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>ACUTE PERITONITIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ACUTE PERITONITIS</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>198X</b>  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>yes</b> |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)      |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                         |  |
| 22a. I certify that <b>I</b> (this hospital) attended the deceased from <b>April 17</b> , 19 <b>68</b> , to <b>October 17</b> , 19 <b>68</b> , that <b>I</b> (we) last saw the deceased alive on <b>October 17</b> , 19 <b>68</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>I</b> (we) (did <b>not</b> ) view the body after death.                                     |   |   |   |  |  |
| 22b. SIGNATURE<br><b>R. N. Hood</b>  |   | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                      |   | 22c. DATE SIGNED<br><b>Oct. 18, 1968</b>   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>LCDR R.N. HOOD MC USN</b>   |   | 22e. ADDRESS<br><b>Naval Hospital, Bethesda, Md.</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>18 OCT 68</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moline Riverside Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Moline Ill.</b>                             |  |  |
| 24. FUNERAL DIRECTOR<br><b>W. W. Chambers Co.</b>  |   | ADDRESS<br><b>1400 Chapin St., N.W., Washington, D. C.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>OCT 22 1968</b>  | 25b. SIGNATURE<br><b>W. W. Chambers</b>  |





14682

14690

## CERTIFICATE OF DEATH

|  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>HYMAN</b>   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>10 16 68</b>  |  |  | 2b. HOUR<br><b>3:55 AM</b>  |  |  |   |  |  |
| 3. SEX<br><b>MALE</b>  |  |  | 4. RACE<br><b>white</b>  |  |  | 5. DATE OF BIRTH<br><b>3-10-88</b>  |  |  | 6. AGE (In years last birthday)<br><b>80</b> YRS.                                 |  |  |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>POLAND</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>AMER.</b>   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.                                       |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Wash. San + Hosp.</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired Grocery</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Food</b>                                  |  |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>md.</b>  |  |  | 13b. COUNTY<br><b>Montgomery</b>   |  |  | 13c. CITY OR TOWN<br><b>Silver Spg.</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  | 13e. STREET AND NUMBER<br><b>4210 Harvard St.</b> |  |  |
| 14. FATHER'S NAME<br><b>Victor</b>   |  |  | First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Rachel</b>   |  |  | First Middle Last<br><b>?</b>   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br><b>no</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>579-46-0311</b>   |  |  | 17. INFORMANT<br><b>Patient's chart</b>   |  |  | Address   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL FAILURE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 WEEK</b><br><b>5 YRS.</b> |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4221 DIABETES MELLITUS</b>  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>Hour A.M. Month Day Year<br>P.M. 19   |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE, 1964</b> , to <b>OCT 16, 1968</b> , that (I) (we) last saw the deceased alive on <b>OCT. 15, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><b>Robert L. Krichmar</b>  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  |  | 22c. DATE SIGNED<br><b>OCT-16-1968</b>  |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>ROBERT L. KRICHMAR MD.</b>  |  |  |  |  |  | 22e. ADDRESS<br><b>7733 ALASKA AVENUE N.W.<br/>WASHINGTON D.C. 20012</b>  |  |  |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  |  | 23b. DATE<br><b>10-18-1968</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NAT'L MEMORIAL PARK</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>FALLS CHURCH VA.</b>          |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>GOLDBERG FUNERAL HOME 4217 9TH ST. N.W.</b>   |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 21 1968</b>  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                |  |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed in the funeral director's office. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon pages 3 and 4. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Revised 4/24/2004

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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14683

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |         |  |        |  |   |  |           |
|--|---------|--|--------|--|---|--|-----------|
| 1. DECEASED-NAME<br>(Type or Print)  |         | First  | Middle | Lost   | 2a. DATE KNOWN OF DEATH<br>Month <input checked="" type="checkbox"/> Day Year |  | 2b. HOUR  |
| MEREDITH   |         | J.   |        | LINNANE  | 10/20 1968  |  | 9:13 P.M. |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH   |        | 6. AGE (In years last birthday)  | 7c. DATE PRONOUNCED DEAD<br>Month Day Year                                    |  | 2d. HOUR  |
| Male   | White   | 4/4/1911   |        | 57 YRS.  | 10 - 20 1968  |  | 9:13 P.M. |
| 7a. BIRTHPLACE (State or foreign country)  |         | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |           |
| D.C. W. Va.  |         | U. S. A.   |        |  |   | Montgomery Md.   |           |
| 10. CITY OR TOWN OF DEATH  |         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)   |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |           |
| Silver Spring  |         | Holy Cross Hosp.   |        | Carpenter  |   | Contracting  |           |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |         | 13b. COUNTY  |        | 13c. CITY OR TOWN  |   | 13e. STREET AND NUMBER   |           |
| Md.  |         | Montgomery   |        | Silver Spring  |   | 4521 Bennion Rd.   |           |
| 14. FATHER'S NAME  |         | 15. MOTHER'S MAIDEN NAME   |        | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |   | 16b. SOCIAL SECURITY NO.   |           |
| Joseph   |         | Estella  |        | No   |   | Unknown  |           |
| 17. INFORMANT  |         | 18. ADDRESS  |        | 19. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                |           |
| Raymond Linnane  |         | 4521 Bennion Rd. Silver Spring, Md.  |        |  |   |  |           |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |        | 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>  |   | 21b. TIME OF INJURY Month, Day, Year   |           |
| 4129   |         |  |        | CAUSE OF DEATH   |   | 19   |           |
| IMMEDIATE CAUSE (a)  |         | DUE TO, OR AS A CONSEQUENCE OF   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   | 22. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |           |
| Acute Coronary Insufficiency   |         | Coronary Artery Heart Disease  |        |  |   |  |           |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |         | DUE TO, OR AS A CONSEQUENCE OF   |        |  |   |  |           |
|  |         |  |        |  |   |  |           |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |         | 4201   |        |  |   |  |           |
| 21d. INJURY OCCURRED   |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |        | 21f. LOCATION Street or R.F.D. No.   |   | City or Town County State  |           |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |  |        |  |   |  |           |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: |         | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |        | 22b. DATE SIGNED   |   | 10/20/1968   |           |
| ACTUAL SIGNATURE   |         | CHIEF MEDICAL EXAMINER   |        | 23a. REC'D BY REGISTRAR  |   | 23b. REGISTRAR'S SIGNATURE   |           |
| EXAMINER'S NAME (Type)   |         | Belden R. Reap M.D.  |        | OCT 25 1968  |   | Charles Judge  |           |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |         | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)                                    |           |
| Burial   |         | 10-23-1968   |        | Gate of Heaven Cemetery  |   | Silver Spring Montgomery Md.   |           |
| 24. FUNERAL DIRECTOR   |         | 25a. ADDRESS   |        | 25b. ADDRESS   |   | 25c. ADDRESS   |           |
| C. Glen Carter   |         | 8434 Ga. Ave.  |        | Silver Spring, Md.   |   |  |           |

14881

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

10-10-68

TO :

FROM :

SUBJECT :

RE :

DATE :

TIME :

BY :

BY :

BY :

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OCT 15 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |                              |  |  |                                    |   |   |  |  |                            |  |
|---|--|------------------------------|--|--|------------------------------------|---|---|--|--|----------------------------|--|
| 14684   |  |                              |  |  | 14692                              |   |   |  |  |                            |  |
| 1. DECEASED-NAME (Type or print)  |  |                              |  |  | 2a. DATE OF DEATH                  |   |   | 2b. HOUR   |  |                            |  |
| Lillian N Lively  |  |                              |  |  | 26 Oct. 1968                       |   |   | 12:00 A M  |  |                            |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH   |                                    | 6. AGE (In years last birthday)   |   | IF UNDER 1 YEAR  |  |                            |  |
| Female  |  | white                        |  | 12/02/121  |                                    | 76 YRS.   |   | MONTHS DAYS HOURS MIN.   |  |                            |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |   |  |  |                            |  |
| Kansas  |  | USA                          |  |  |                                    | Montgomery County Md.   |   |  |  |                            |  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |   |  | 12b. KIND OF BUSINESS OR INDUSTRY            |                            |  |
| Silver Spring   |  |                              | Holy Cross Hospital  |  |                                    | Staff   |   |  | US Gov't.                                    |                            |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |                              | 13b. COUNTY  |  | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET AND NUMBER                       |                            |  |
| MD.   |  |                              | Pr. Geo.   |  | Lanham                             |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 931 Sheridan St.                             |                            |  |
| 14. FATHER'S NAME   |  |                              | 15. MOTHER'S MAIDEN NAME   |  |                                    |   |   |  |  |                            |  |
| Fred C. Nienke  |  |                              | Minnie Katzenmiere   |  |                                    |   |   |  |  |                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |                              | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address              |   |   |  |  |                            |  |
| no  |  |                              | 217-44-2321  |  | Kellis E. Lively - same as # 13    |   |   |  |  |                            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                              |  |  |                                    |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                            |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure  |  |                              |  |  |                                    |   |   |  | 2 weeks                                      |                            |  |
| 174x DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of Breast  |  |                              |  |  |                                    |   |   |  | 1 yr   |                            |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)  |  |                              |  |  |                                    |   |   |  |  |                            |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)   |  |                              |  |  |                                    |   |   |  |  |                            |  |
| 170x  |  |                              |  |  |                                    |   |   |  |  |                            |  |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |                                    | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                            |  |
|   |  |                              |  |  |                                    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |  |                            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |                              | 21b. TIME OF INJURY  |  |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |   |  |  |                            |  |
|   |  |                              | HOUR A.M. Month Day Year P.M. 19   |  |                                    |   |   |  |  |                            |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |                            |  |
|   |  |                              |  |  |                                    |   |   |  |  |                            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1968, to 10/26, 1968, that (I) (we) last saw the deceased alive on 10/25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |  |                                    |   |   |  |  |                            |  |
| 22b. SIGNATURE G. Leonard Gold, M.D.  |  |                              |  |  |                                    | DEGREE  |   | 22c. DATE SIGNED   |  |                            |  |
|   |  |                              |  |  |                                    | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 10/26/68   |  |                            |  |
| 22d. PHYSICIAN'S NAME (Type) G. Leonard Gold, M.D.  |  |                              |  |  |                                    | 22e. ADDRESS Silver Spring, Maryland  |   |  |  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                              | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION (City or Town) (County) (State)                       |  |  |                            |  |
| Burial  |  |                              | 10-28-68   |  | Ft. Lincoln Cemetery               |   | Colmar Manor Pr. Geo. Md.   |  |  |                            |  |
| 24. FUNERAL DIRECTOR  |  |                              |  |  |                                    | ADDRESS   |   | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE |  |
| F. Gasch's Sons - Hyattsville, Maryland   |  |                              |  |  |                                    |   |   | OCT 29 1968  |  | J Charles Judge            |  |

14581

RECEIVED

14581



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |   |   |  |  |                             |  |
|---|--|--|--|---|---|--|--|-----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |   |   |  |  |                             |  |
| CERTIFICATE OF DEATH  |  |  |  |   |   |  |  |                             |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First  | Middle  | Last  | 2a. DATE OF DEATH  |  |                             | 2b. HOUR                                     |
| EDGAR RICE LOCKE, SR.   |  |  |  |   |   | Month  | Day  | Year                        | P  |
| October 8, 1968   |  |  | September 19, 1904   |   |   | 5:15   |  |                             |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR             |  |
| Male  |  | White  |  | September 19, 1904  |   | 64 YRS.  |  | MONTHS DAYS HOURS MIN.      |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  |                             |  |
| Colorado  |  | U.S.A.   |  |   |   | Montgomery Md.   |  |                             |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  |                             | 12b. KIND OF BUSINESS OR INDUSTRY            |
| Potomac   |  |  | 8204 Post Oak Road,  |   |   | Manager  |  |                             | Oil Co.                                      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER      |  |
| Australia   |  |  | Brisbane   |   | Hamilton  |  |  | Camden Home Units, Unit 6-A |  |
| 14. FATHER'S NAME   |  |  | First  | Middle  | Last  | 15. MOTHER'S MAIDEN NAME   |  |                             | First  |
| Edgar Rice Locke  |  |  |  |   |   | Martha Walker  |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address   |  |  |                             |  |
| Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service)  |  |  | W.W. 11  |   | Not Avail. (Wife) Josephine S. Locke, Same as above   |  |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u><br>1621 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |   |  |  |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>1621   |  |  |  |   |   |  |  |                             |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |  |                             |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |  |  |                             |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1968</u> , 19 <u>68</u> , to <u>Oct 8, 1968</u> , that (I) (we) last saw the deceased alive on <u>Sept 19, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.           |  |  |  |   |   |  |  |                             |  |
| 22b. SIGNATURE <u>Jerre J. Daum</u> DEGREE  |  |  |  |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED   |                             |  |
| 22d. PHYSICIAN'S NAME (Type) JERRE J. DAUM, M.D.  |  |  |  |   | 22e. ADDRESS 4977 Battery Lane, Bethesda, Md.   |  |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION (City or Town) (County) (State)  |  |                             |  |
| Removal   |  | 10/9/68  |  | Fairmount Cemetery  |   | Denver, Denver Co. Colorado  |  |                             |  |
| 24. FUNERAL DIRECTOR  |  |  |  |   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |                             |  |
| ROBERT A. PUMPHREY, Bethesda, Maryland.   |  |  |  |   | DATE OCT 11 1968  |  | J. Charles Judge   |                             |  |

14003

14003

DEPT. OF JUSTICE

REPORT OF THE UNITED STATES DEPARTMENT OF JUSTICE

INVESTIGATION OF THE ACTS OF VIOLENCE COMMITTED BY THE

MEMBERS OF THE BLACK PANTHER PARTY

IN THE CITY OF NEW YORK

ON OCTOBER 1, 1969

BY THE NEW YORK OFFICE OF THE ATTORNEY GENERAL

AND THE NEW YORK OFFICE OF THE DISTRICT ATTORNEY

IN CONNECTION WITH THE

ACTS OF VIOLENCE COMMITTED BY THE

MEMBERS OF THE BLACK PANTHER PARTY

IN THE CITY OF NEW YORK

ON OCTOBER 1, 1969

BY THE NEW YORK OFFICE OF THE ATTORNEY GENERAL

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IN CONNECTION WITH THE

ACTS OF VIOLENCE COMMITTED BY THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14686

CERTIFICATE OF DEATH

14694

|   |  |  |  |   |      |   |  |   |  |   |      |
|---|--|--|--|---|------|---|--|---|--|---|------|
| 1. DECEASED-NAME<br>(Type or print) <b>MARGARET</b>   |  |  | First  | Middle  | Last | 2a. DATE OF DEATH<br><b>10</b> Month <b>12</b> Day <b>68</b> Year   |  |   | 2b. HOUR<br><b>1:55 A M</b>  |   |      |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>                    |  | 5. DATE OF BIRTH<br><b>2-11-1868</b>  |      | 6. AGE (In years last birthday)<br><b>100</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |      |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  | 8. <input checked="" type="checkbox"/> NEVER MARRIED<br><input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED |      | 9. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |   |  |   |      |
| 10. CITY OR TOWN OF DEATH<br><b>SILVER SPRING Md.</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>FAIRLAND NURSING HOME</b> |   |      | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b> |  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>                     |   |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MD</b>  |  |  | 13b. COUNTY<br><b>MONTGOMERY</b>   |   |      | 13c. CITY OR TOWN<br><b>Silver Spring</b>   |  | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                 |  | 13e. STREET AND NUMBER<br><b>234 Dale Drive</b>                             |      |
| 14. FATHER'S NAME<br><b>JOHN A</b>  |  |  | First  | Middle  | Last | 15. MOTHER'S MAIDEN NAME<br><b>MARGARET E. CRAWFORD</b>   |  |   | First  | Middle  | Last |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>NO</b>  |  |  | (If yes give war or dates of service)  |   |      | 16b. SOCIAL SECURITY NO.<br><b>219-54-8234</b>  |  | 17. INFORMANT<br><b>Mrs. Bertha U. Quick 234 Dale Drive</b>   |  |   |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia, left lower lobe</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic cardiovascular disease</b>    |  |  |  |   |      |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>72 hrs</b><br><b>" "</b> |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>4221</b>  |  |  |  |   |      |   |  |   |  |   |      |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |      | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |   |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                             |  |   |  |   |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                 |   |      | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |   |  |   |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>August 21 1968</b> , to <b>October 19 1968</b> , that (I) (we) last saw the deceased alive on <b>October 12 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |      |   |  |   |  |   |      |
| 22b. SIGNATURE<br><b>Raymond Bradshaw, MD</b>   |  |  |  |   |      | DEGREE<br><b>MD</b>   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>Oct. 13, 1968</b>                                    |      |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Raymond Bradshaw</b>   |  |  |  |   |      | 22e. ADDRESS<br><b>345 University Blvd., W. Silver Spring, Md.</b>  |  |   |  |   |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>10-15-1968</b>   |   |      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>  |  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington D. C.</b> |   |      |
| 24a. REGISTRAR'S SIGNATURE<br><b>Warner E. Pumphrey, Inc. 8434 Ga. Ave. S.S. Md.</b>  |  |  |  |   |      | 24b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 21 1968</b>  |  |   |      |

1952

CENTRAL OF DEATH

1952



RECEIVED

10-1-1952  
C. J. ...  
...

OUT 1952

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

14695

14687

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |   |   |   |   |   |  |  |  |
|---|--|--|---|---|---|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Josephine F. LOWE</b>  |  |  | 2a. DATE OF DEATH<br>Oct. 13 1968   |   |   | 2b. HOUR<br>848P M.   |   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br><b>2May 1925</b>  |   | 6. AGE (In years last birthday)<br><b>43</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Rhode Island</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                   |   | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.   |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Naval Hospital</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)<br><b>Registered nurse</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Health</b>       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Virginia</b>   |  |  | 13b. COUNTY<br><b>Arlington</b>   |   | 13c. CITY OR TOWN<br><b>Arlington</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>2943 S. Columbus Street</b> |  |
| 14. FATHER'S NAME<br><b>William M. McDermott</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Margaret Quinlan</b>   |   |   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>- Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.<br><b>030-18-8162</b>  |   | 17. INFORMANT <b>Arlington</b> Address <b>Va.</b><br><b>Mr. Kenneth R. Lowe, 2943 S. Columbus St.</b>                                     |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of breast with metastases to abdominal viscera</b><br><b>174X</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____         |  |  |   |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |
|   |  |  |   |   |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>170X</b>  |  |  |   |   |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>yes</b>              |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |   |   |  |  |  |
| 22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>Mar. 20</b> , 19 <b>68</b> , to <b>Oct. 13</b> , 19 <b>68</b> , that <del>he</del> (we) last saw the deceased alive on <b>Oct. 13</b> , 19 <b>68</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>not</del> view the body after death. |  |  |   |   |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>D. L. Colgan</b> M.D.  |  |  |   |   | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>Oct. 14, 1968</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>D. L. COLGAN, M.D.</b>   |  |  |   |   | 22e. ADDRESS<br><b>Naval Hospital, Bethesda, Md.</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National Cemetery</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Arlington Virginia</b>                      |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>W. W. Chambers Co.</b>   |  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>OCT 16 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |  |  |
| 8655 Georgia Ave., Silver Spring, Md.   |  |  |   |   |   |   |   |  |  |  |



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revised version

January 1967, M. Saito

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*(continued)*

Continuation of Form FD-302 (Rev. 11-27-70)

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Naval Hospital, Bethesda, Md.

U.S. DEPT. OF JUSTICE

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## Index

W. J. Connelley, Jr.

1955 George A. & Silver Springs, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14688

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14696

CERTIFICATE OF DEATH

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED-NAME<br>(Type or print)<br><b>JAMES PRESTON LYNN</b>  |   |   | 2a. DATE OF DEATH<br>Month <b>10</b> Day <b>17</b> Year <b>68</b>                               |   | 2b. HOUR<br><b>4:10</b> P M   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>COLORED</b>   | 5. DATE OF BIRTH<br><b>3/9/06</b>   |   | 6. AGE (In years last birthday)<br><b>62</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS<br>IF UNDER 24 HRS.<br>HOURS MIN.                     |
| 7a. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>MONTGOMERY</b> Md.   |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>OLNEY</b>   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>MONTGOMERY GENERAL</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>LABORER</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>UTILITIES</b>   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  | 13b. COUNTY<br><b>MONTGOMERY</b>  | 13c. CITY OR TOWN<br><b>SPENCERVILLE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER<br><b>BROGDEN ROAD</b>   |   |
| 14. FATHER'S NAME<br>First <b>JOSEPH</b> Middle <b>L.</b> Last <b>LYNN</b>  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>MARY</b> Middle <b>L.</b> Last <b>--</b>   |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>MEDICAL RECORDS</b> Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4459</b> IMMEDIATE CAUSE (a) <b>Blood loss + Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hemorrhagic Gastritis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>457X</b> (c) |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>2-3 wks</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Multiple Pulmonary Infarcts - Emboli - Thrombophlebitis - Femoral</b>   |   |   |   |   |   |
| 19a. DATE OF OPERATION<br><b>8-12-68</b>  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Arterial Occlusion - Gangrene</b>                  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b>  |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |   | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                 |   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                              |   | 21f. LOCATION Street or R.F.D. No.  | City or Town  | County State  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>7/24, 1968</b> , to <b>10/17, 1968</b> , that (I) (we) last saw the deceased alive on <b>10/17, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                   |   |   |   |   |   |
| 22b. SIGNATURE<br><b>Richard A. Yates M.D.</b>  |   |   | DEGREE<br><b>M.D.</b>   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED<br><b>10/18/68</b>   |
| 22d. PHYSICIAN'S NAME (Type)<br><b>RICHARD A. YATES, M.D.</b>   |   |   | 22e. ADDRESS<br><b>OLNEY, MARYLAND</b>  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE<br><b>10-22-68</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ASH Memorial Cem.</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Sandy Spring Montg. Md.</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Robert L. Snowden Rockville Md</b>   |   | ADDRESS   | 25a. REC'D BY REGISTRAR<br><b>DATE OCT 3 1968</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Richard A. Yates</b>   |   |

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STATE OF OHIO

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

|   |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Grace</b>  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH<br><b>Oct.</b> Month <b>11</b> Day <b>1968</b> Year   |  |  | 2b. HOUR<br><b>3:30</b>  |  |  |
| 3. SEX<br><b>female</b>   |  |  | 4. RACE<br><b>white</b>  |  |  | 5. DATE OF BIRTH<br><b>6-7-1875</b>   |  |  | 6. AGE (In years last birthday)<br><b>93</b> YRS.  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Iowa</b>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Colonial Villa 12325 New Hamp. Ave., SS, Md</b> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Secretary</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Church</b>   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Mont.</b>  |  |  | 13c. CITY OR TOWN<br><b>Takoma Pk</b>   |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br><b>John H. Durland</b>   |  |  | First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME<br><b>Flora Runnels Durland</b>  |  |  | First Middle Last  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown <b>no</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>578-44-8032</b>   |  |  | 17. INFORMANT<br><b>Nursing Home Records, Colonial Villa</b>  |  |  | Address  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral thrombosis left hemisphere</b><br><b>4330</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>with gradual onset of paralysis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>332x</b><br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF _____<br>(c) <b>Branches pneumonia stroke</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b><br><b>7 day</b> |  |  |  |  |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><b>Gen Arteriosclerosis Hypertension Previous CVA</b>  |  |  |  |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>11/5/68</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)   |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/5/68</b> , to <b>10/11/68</b> , that (I) (we) last saw the deceased alive on <b>10/11/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Howard T. Morse</b>  |  |  | DEGREE<br><b>M.D.</b>  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><b>10/11/68</b>  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Howard T. Morse M.D.</b>   |  |  | 22e. ADDRESS<br><b>1030 Carroll Ave Takoma Park Md</b>   |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>Oct 14, 1968</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>George Washington</b>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Adelphi Md</b>                           |  |  |
| 24. FUNERAL DIRECTOR<br><b>Arthur Walters, 254 Carroll St. NW. DC</b>   |  |  | ADDRESS  |  |  | 25a. REC'D BY REGISTRAR<br><b>OCT 14 1968</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Jones</b>  |  |  |

1889

OFFICE OF THE  
TREASURER OF THE  
UNITED STATES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|--|---|--|---|--|--|--|
| 14690  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                     |  |   |  | 14698  |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) <i>Eunice M. Macuch</i>  |  |   | 2a. DATE OF DEATH<br>Month <i>Oct</i> Day <i>31</i> Year <i>68</i> |   |  | 2b. HOUR<br><i>9:45</i> M  |  |
| 3. SEX<br><i>F</i>   |  | 4. RACE<br><i>W</i>   |  | 5. DATE OF BIRTH<br><i>12/27/35</i>   |  | 6. AGE (In years last birthday)<br><i>42</i> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>D.C.</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Montgomery</i> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Bethesda</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Suburban</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Sales Clerk</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Montgomery</i>  |  | 13c. CITY OR TOWN<br><i>Rockville</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><i>1912 Stanley Ave</i>  |  | 14. FATHER'S NAME<br>First <i>Clayton</i> Middle <i>Railley</i> Last <i>Railley</i>             |  | 15. MOTHER'S MAIDEN NAME<br>First <i>Eunice M.</i> Middle <i>Oliver</i> Last <i>Oliver</i>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><i>220-12-3321</i>  |  | 17. INFORMANT<br><i>William Macuch</i>  |  | Address <i>Same as above</i>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4309 Cerebral Hemorrhage</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Berry Aneurysm</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>5 days</i>                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><i>330X</i>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>                               |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                    |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>10/25/68</i> , 19 <i>68</i> , to <i>10/31/68</i> , that (I) (we) last saw the deceased alive on <i>10/31/68</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.       |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Robert C. Macor</i>   |  | 22c. DATE SIGNED<br><i>10/31/68</i>   |  | 22d. PHYSICIAN'S NAME (Type)<br><i>ROBERT C. MACON</i>  |  | 22e. ADDRESS<br><i>809 Viers Mill Rd, Rockville</i>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 23b. DATE<br><i>11/2/68</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Parklawn</i>   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Rockville, Maryland</i>                  |  |
| 24. TYSON WHEELER<br><i>1331 Rockville Pike</i><br><i>Rockville, Maryland 20852</i>  |  | 25a. REC'D BY REGISTRAR<br><i>NOV 4 1968</i>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>J Charles Judge</i>  |  |  |  |



1955

1955



*[Faint, mostly illegible handwritten text, possibly a letter or document.]*

*[Faint, mostly illegible handwritten text, possibly a signature or date.]*

NOV 1 1955



## CERTIFICATE OF DEATH

14691

14699

|  |  |   |  |   |  |  |  |  |  |                                |  |
|--|--|---|--|---|--|--|--|--|--|--------------------------------|--|
| 1. DECEASED NAME<br>(Type or print)  |  | First<br><b>FRANK</b>   |  | Middle<br><b>E.</b>   |  | Last<br><b>MADDUX</b>  |  | 6a. DATE OF DEATH<br>Month Day Year<br><b>October 12, 1968</b>       |  | 2b. HOUR P.<br><b>6:10 PM</b>  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Cauc.</b>   |  | 5. DATE OF BIRTH<br><b>Oct. 11, 1898</b>  |  | 6. AGE (In years last birthday)<br><b>70</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |  | IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Montgomery</b>  |  |  |  |                                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Nursing Home Grosvenor</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Fisherman</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |                                |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Prince George</b>   |  | 13c. CITY OR TOWN<br><b>District Heights</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>7108 Walker Mill Road</b>               |  |                                |  |
| 14. FATHER'S NAME First Middle Last<br><b>Unknown</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Unknown Wash. DC.</b>  |  |  |  |  |  |                                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>WW I 220-12-3088</b>   |  | 17. INFORMANT Address<br><b>Ida Pearl Johnson 7108 Walker Mill Rd</b>   |  |  |  |  |  |                                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b><br><b>1579</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized carcinomatosis</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinoma of pancreas</b><br><b>4 months</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>157x</b> |  |   |  |   |  |  |  |  |  |                                |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |                                |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |                                |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/20</b> , 19 <b>68</b> , to <b>10/13</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/11</b> , 19 <b>68</b> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |   |  |   |  |  |  |  |  |                                |  |
| 22b. SIGNATURE<br><b>Wilfred R. Ehrmantraut MD</b>   |  | DEGREE ATTENDING PHYS. MED. DIRECTOR STAFF PHYS.  |  | 22c. DATE SIGNED<br><b>10/13/68</b>   |  |  |  |  |  |                                |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Wilfred R. Ehrmantraut</b>  |  | 22e. ADDRESS<br><b>1125 Rockville Pike Bethesda, Md 20812</b>   |  |   |  |  |  |  |  |                                |  |
| 23a. BURIAL, CREMATION, REMOVAL (Type)<br><b>Burial</b>  |  | 23b. DATE<br><b>10-16-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   |  | 23d. LOCATION (City, town, county, state)<br><b>Baltimore, Maryland</b>                      |  |  |  |                                |  |
| 24. FUNERAL DIRECTOR<br><b>Robert A. Pumphrey 7557 Wisconsin Ave Bethesda, Md</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>OCT 18 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>   |  |  |  |                                |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14889

RECEIVED 12-12-58

14889

DECEMBER 12, 1958

MEMORANDUM

TO :

FROM :

SUBJECT :

RE :

1. MEMORANDUM

2. MEMORANDUM

3. MEMORANDUM

4. MEMORANDUM

5. MEMORANDUM

6. MEMORANDUM

7. MEMORANDUM

8. MEMORANDUM

9. MEMORANDUM

10. MEMORANDUM

11. MEMORANDUM

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15. MEMORANDUM

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17. MEMORANDUM

18. MEMORANDUM

19. MEMORANDUM

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22. MEMORANDUM

23. MEMORANDUM

24. MEMORANDUM

25. MEMORANDUM

26. MEMORANDUM

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28. MEMORANDUM

29. MEMORANDUM

30. MEMORANDUM

31. MEMORANDUM

32. MEMORANDUM

33. MEMORANDUM

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |  |  |  |                            |
|---|--|---|--|---|--|--|--|--|----------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |  |  |  |                            |
| 14692   |  |   |  |   |  |  |  |  |                            |
| 14700   |  |   |  |   |  |  |  |  |                            |
| CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |                            |
| 1. DECEASED-NAME<br>(Type or print) <b>Bernard</b>  |  |   | First <b>F</b> Middle <b>MA</b> Last <b>Magruder</b>                                 |   |  | 2a. DATE OF DEATH<br>Month <b>10</b> Day <b>27</b> Year <b>68</b>                            |  |  | 2b. HOUR<br><b>7:30</b> AM |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br><b>8-11-95</b>  |  | 6. AGE (In years last birthday)<br><b>73</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN. |                            |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>MONTGOMERY</b> Md.  |  |  |                            |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SUBURBAN</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Dir. of Eastern Reg. Board</b>                                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |                            |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>MONTGOMERY</b>  |  | 13c. CITY OR TOWN<br><b>CHEV CHASE</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>7306 MAPLE AVENUE</b>                   |                            |
| 14. FATHER'S NAME<br>First <b>CHARLES</b> Middle <b>MA</b> Last <b>Magruder</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>First <b>OLA</b> Middle <b>FEWELL</b> Last <b>FEWELL</b> |   |  |  |  |  |                            |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <b>YES</b> (If yes give war or dates of service)<br><b>W.W.I. - ARMY</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>316-10-7451</b>  |  | 17. INFORMANT<br><b>MARTIN C. MAGRUDER</b> Address <b>SAME AS ABOVE</b>   |  |  |  |  |                            |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1621 POSTOPERATIVE BRONCHO PLEURAL PISTULA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>PULMONARY RESECTION - BRONCHO -</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>GENIC CARCINOMA</b>       |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 DAYS</b><br><b>2 MONTHS +</b>           |  |  |                            |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>1621</b>  |  |   |  |   |  |  |  |  |                            |
| 19a. DATE OF OPERATION<br><b>10-1-68</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>BRONCHIAL CARCINOMA</b>                  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |                            |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                               |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |                            |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                    |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |  |  |                            |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-1-68</b> , to <b>10-27-68</b> , that (I) (and) last saw the deceased alive on <b>10-27-68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |                            |
| 22b. SIGNATURE<br><b>J. W. Peabody Jr.</b>  |  | 22c. DATE SIGNED<br><b>10-27-68</b>   |  | 22d. PHYSICIAN'S NAME (Type)<br><b>J. W. PEABODY JR. MD</b>   |  |  |  |  |                            |
| 22e. ADDRESS<br><b>1234 19th ST. N.W. WASH. D.C.</b>  |  |   |  |   |  |  |  |  |                            |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>10-30-68</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b>                   |  |  |                            |
| 24. FUNERAL DIRECTOR<br><b>Robert A Pumphrey 7557 Wisconsin Ave Bethesda, Md</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>NOV 4 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |  |  |                            |

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |   |  |                      |  |
|---|--|--|--|--|--|--|--|---|--|----------------------|--|
| <div>14693</div> <div>Items #1, 14 &amp; 17, Film</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>1/6/69 kk</div> <div>14701</div>  |  |  |  |  |  |  |  |   |  |                      |  |
| 1. DECEASED-NAME<br>(Type or Print)   |  | First<br>RUSSELL   |  | Middle<br>JOSEPH   |  | Last<br>MALONY   |  | 20. DATE KNOWN OF ESTI-DEATH MATED          |  | 2b. HOUR             |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>DEC. 17 1919   |  | 6. AGE (In years last birthday)<br>48 YRS.   |  | 7. DATE PRONOUNCED DEAD<br>October 23, 1968 |  | 8. HOUR<br>8:15 P.M. |  |
| 7a. BIRTHPLACE (State or foreign country)<br>10 WA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>MONTGOMERY   |  |   |  |                      |  |
| 10. CITY OR TOWN OF DEATH<br>Gaithersburg   |  | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)<br>RFD.#2 Box 202 |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>MANAGER   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOTEL   |  |   |  |                      |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE<br>Md.  |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Gaithersburg  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>RFD.#2 Box 202    |  |                      |  |
| 14. FATHER'S NAME   |  | First<br>RUSSELL   |  | Middle<br>Malony   |  | Last<br>MALONY   |  | 15. MOTHER'S MAIDEN NAME                    |  | First<br>JOSEPHINE   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>YES  |  | 16b. SOCIAL SECURITY NO.<br>(If yes give year or dates of service)<br>WA 11                    |  | 17. INFORMANT<br>Maloney Malony  |  | ADDRESS<br>EVALIN MALONY   |  | GAITHERSBURG                                |  |                      |  |
| <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>PART 1. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u></div> <div>4129 DUE TO, OR AS A CONSEQUENCE OF</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>(b) _____ DUE TO, OR AS A CONSEQUENCE OF</div> <div>(c) _____</div>      |  |  |  |  |  |  |  |   |  |                      |  |
| <div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</div> <div>4221</div>   |  |  |  |  |  |  |  |   |  |                      |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |                      |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                                   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |   |  |                      |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |   |  |                      |  |
| <div>22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></div> |  |  |  |  |  |  |  |   |  |                      |  |
| ACTUAL SIGNATURE  |  | Charles S. Springate   |  | M.D.   |  | 22b. DATE SIGNED<br>October 24, 1968   |  |   |  |                      |  |
| EXAMINER'S NAME (Type)  |  | Charles S. Springate   |  | ADDRESS (Street, city, town, or county)  |  |  |  |   |  |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>REMOVAL  |  | 23b. DATE<br>OCT. 25 1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>PITTSFIELD VILLAGE   |  | 23d. LOCATION (City or Town) (County) (State)<br>PITTSFIELD MAINE                    |  |   |  |                      |  |
| 24. FUNERAL DIRECTOR  |  | ADDRESS<br>Francis H. Barber Gaytonville Md.   |  | 25a. REC'D BY REGISTRAR<br>DATE OCT 28 1968  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |  |   |  |                      |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14696

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14702

|   |  |   |  |   |   |
|---|--|---|--|---|---|
| 1. DECEASED-NAME<br>(Type or print) <b>SALVATORE</b>  |  | First Middle Last   | 2a. DATE OF DEATH<br>Month Day Year <b>OCTOBER 8 1968</b>                                    |   | 2b. HOUR<br><b>10 PM</b>  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br><b>11-4-1898</b>  |  | 6. AGE (In years last birthday)<br><b>69</b> YRS.                 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.         |
| 7a. BIRTHPLACE (State or foreign country)<br><b>SCILIA</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>MONTGOMERY</b> Md.  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>SUBURBAN HOSPITAL</b> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Retired</b>   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>DISTRICT OF COLUMBIA</b>  | 13b. COUNTY<br><b>WASHINGTON</b>   | 13c. CITY OR TOWN<br><b>WASHINGTON</b>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br><b>4611 ASBURY PL. WASHINGTON, D.C.</b> |   |
| 14. FATHER'S NAME<br><b>JOSEPH</b>  | First Middle Last  | 15. MOTHER'S MAIDEN NAME<br><b>ROSE UNKNOWN</b>   | First Middle Last  | 15. MOTHER'S MAIDEN NAME<br><b>CAVIDAN</b>                        |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown<br><b>NO</b>   | 16b. SOCIAL SECURITY NO.<br><b>577-48-088</b>  | 17. INFORMANT<br><b>ANTONIO</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arterio Sclerotic Cardio Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>4109</b> |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>one hour</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>   |  |   |  |   |   |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                             | 21f. LOCATION Street or R.F.D. No.  | City or Town   | County  | State   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>68</b> , to <b>Oct 8</b> , 19 <b>68</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Oct 8</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.             |  |   |  |   |   |
| 22b. SIGNATURE<br><b>DeWitt E. DeLauter MD</b>  | DEGREE<br><b>MD</b>  | ATTENDING PHYS.<br><input checked="" type="checkbox"/>  | MED. DIRECTOR <input type="checkbox"/>   | STAFF PHYS.<br><input type="checkbox"/>                           | 22c. DATE SIGNED<br><b>OCT 8, 1968</b>                          |
| 22d. PHYSICIAN'S NAME (Type)<br><b>DeWitt E. DeLauter</b>   | 22e. ADDRESS<br><b>3848 PORTER ST. NW WASH D.C.</b>  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE<br><b>10-12-1968</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. MARY'S CEMETERY</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>WASHINGTON D.C.</b>                      |   |   |
| 24. FUNERAL DIRECTOR<br><b>Robert A. DeVol</b>  | DEVELOPMENTAL<br><b>DEVOI</b>  | ADDRESS<br><b>HOME WASH D.C.</b>  | 25a. REC'D BY REGISTRAR<br><b>OCT 16 1968</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>             |   |

18702

18702



18702

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME<br>(Type or print)   |                              | First  | Middle  | Last  | 2a. DATE OF DEATH<br>Month Day Year |  |                                | 2b. HOUR                                    |  |
|---|------------------------------|--|---|---|-------------------------------------|--|--------------------------------|---|--|
| Edgar Mason   |                              |  |   |   | Oct                                 | 4  | 1968                           | 1254  | PM   |
| 3. SEX  | 4. RACE                      |  | 5. DATE OF BIRTH  |   | 6. AGE (In years last birthday)     |  | IF UNDER 1 YEAR<br>MONTHS DAYS |   | IF UNDER 24 HRS.<br>HOURS MIN.               |
| Male  | Caucasian                    |  | 1-21-1883   |   | 85 YRS.                             |  |                                |   |  |
| 7a. BIRTHPLACE (State or foreign country)   | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH                  |  |                                |   |  |
| W. Va   | America                      |  |   |   | Montgomery Mo.                      |  |                                |   |  |
| 10. CITY OR TOWN OF DEATH   |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |                                     | 12b. KIND OF BUSINESS OR INDUSTRY  |                                |   |  |
| Kensington Md.  |                              | Bensington Gardens Sanitarium  |   | Worker  |                                     | Shipping Clerk   |                                |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE   |                              | 13b. COUNTY  |   | 13c. CITY OR TOWN   |                                     | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                | 13e. STREET AND NUMBER                      |  |
| Md  |                              | Montgomery   |   | Takoma Park   |                                     | YES  |                                | 6616 Westmanland Ave                        |  |
| 14. FATHER'S NAME   |                              | 15. MOTHER'S MAIDEN NAME   |   |   |                                     |  |                                |   |  |
| First Middle Last   |                              | First Middle Last  |   |   |                                     |  |                                |   |  |
| H L Mason   |                              | Nancy Frank  |   |   |                                     |  |                                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |                              | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |                                     | Address  |                                |   |  |
| No  |                              | 224-10-9971A   |   | Harold Mason  |                                     | Takoma Park Md   |                                |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |                              |  |   |   |                                     |  |                                |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |                              |  |   |   |                                     |  |                                |   |  |
| IMMEDIATE CAUSE (a) <u>RENAL INSUFFICIENCY</u>  |                              |  |   |   |                                     |  |                                |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u>  |                              |  |   |   |                                     |  |                                |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |                              |  |   |   |                                     |  |                                |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |                              |  |   |   |                                     |  |                                |   |  |
| 4221  |                              |  |   |   |                                     |  |                                |   |  |
| 19a. DATE OF OPERATION  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |   | 20a. AUTOPSY?   |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                |   |  |
|   |                              |  |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                                |                                     |  |                                |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |                              | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |                                     |  |                                |   |  |
|   |                              |  |   |   |                                     |  |                                |   |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |                              | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |   | 21f. LOCATION Street or R.F.D. No.  |                                     | City or Town   |                                | County                                      | State  |
|   |                              |  |   |   |                                     |  |                                |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1968, to Feb 1968, that (I) (we) lost saw the deceased alive on Oct 3 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |                              |  |   |   |                                     |  |                                |   |  |
| 22b. SIGNATURE<br>Bernard A Fitzgerau   |                              |  |   | DEGREE<br>ATTENDING PHYS.   |                                     | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>       |                                | 22c. DATE SIGNED<br>10-4-68                 |  |
| 22d. PHYSICIAN'S NAME (Type)<br>BERNARD A. FITZGERAUS   |                              |  |   | 22e. ADDRESS<br>217 UNIV. BLVD EAST SALT SPRING MD                                      |                                     |  |                                |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                              | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY  |                                     | 23d. LOCATION (City or Town)   |                                | (County)                                    | (State)                                      |
| Burial  |                              | 10-7-68  |   | MT. HEARON  |                                     | WINCHESTER   |                                |   | VIRGINIA                                     |
| 24. FUNERAL DIRECTOR<br>James H. Fleming  |                              |  |   | ADDRESS<br>Winchester, Va.  |                                     | 25a. REC'D BY REGISTRAR<br>DATE OCT 9 1968   |                                | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge |  |

MEDICAL CERTIFICATION

14703

14703

RECEIVED BY MAIL

[Faint, mostly illegible text covering the main body of the document, possibly a letter or report.]



14703

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 14696  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |  |  |  |  | 14704   |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 1. DECEASED-NAME (Type or print) <b>JOAN</b>   |  |  |  |  | First Middle Last  |  |  |  |  | 2a. DATE OF DEATH <b>October 12 - 68</b>   |  |  |  |  | 2b. HOUR <b>4:50 PM</b>  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX <b>Female</b>   |  |  |  |  | 4. RACE <b>White</b>   |  |  |  |  | 5. DATE OF BIRTH <b>7/4/32</b>   |  |  |  |  | 6. AGE (In years last birthday) <b>36</b> YRS.                         |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) <b>N.C.</b>  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  | 9. COUNTY OF DEATH <b>Montgomery</b> Md.                               |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>   |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Holy Cross</b> |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Area Sales Rep.</b>   |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Hornery Co.</b>                   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>  |  |  |  |  | 13b. CITY OR TOWN <b>Bowie</b>   |  |  |  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 13e. STREET AND NUMBER <b>3507 Maleck Lane</b>                         |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME <b>Robert J. Lowery</b>  |  |  |  |  | First Middle Last  |  |  |  |  | 15. MOTHER'S MAIDEN NAME <b>Doris Panker</b>   |  |  |  |  | First Middle Last  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>No</b> (If yes give war or dates of service)  |  |  |  |  | 16b. SOCIAL SECURITY NO. <b>223-36-9854</b>  |  |  |  |  | 17. INFORMANT <b>John Maume</b>  |  |  |  |  | Address <b>3507 Maleck Lane, Bowie, Md</b>                             |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Intestinal Pneumonia, Bilateral</b><br><b>5110</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>5192</b><br>(b) <b>Hydrothorax, Bilateral</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Pelvic Peritonitis; Renal Papillitis</b>   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>                                    |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                   |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 9, 1968</b> , to <b>Oct 12, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 12, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>Blaine H. ETC</b>  |  |  |  |  |  |  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  |  |  |  | 22c. DATE SIGNED <b>10/12/1968</b>                                     |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>BLAINE H. ETC</b>  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS <b>9801 Georgia Avenue</b>  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  |  |  | 23b. DATE <b>10-16-1968</b>  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State) <b>Hampton, Virginia</b> |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <b>C. Glen Carter</b>   |  |  |  |  |  |  |  |  |  | ADDRESS <b>Sil. Spr. Md.</b>   |  |  |  |  | 25a. REC'D BY REGISTRAR <b>OCT 21 1968</b>                             |  |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>      |  |  |  |  |  |  |  |  |  |
| 26. REGISTRAR'S SIGNATURE <b>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</b>  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |



JOHN

Intestinal, chronic, bilateral

Varicella, bilateral

Intestinal, chronic, bilateral



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

14697

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14705

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><i>Catherine M<sup>c</sup> Carthy</i>   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><i>Oct. 13 1968</i>      |   |  | 2b. HOUR<br><i>350 PM</i>  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>Caucasian</i>  |   | 5. DATE OF BIRTH<br><i>Feb 2 1883</i>   |  | 6. AGE (In years last birthday)<br><i>85</i>                                     |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>England</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><i>Montgomery</i>  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>1115 Meade Lane</i> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Housewife</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>OWN HOME</i>                             |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARY</i> COUNTY <i>Worcester</i>  |  | 13b. CITY OR TOWN<br><i>Worcester</i>  |   | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET AND NUMBER<br><i>7 Vassar St</i>                                     |  |
| 14. FATHER'S NAME First Middle Last<br><i>Patrick Melvin</i>   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><i>Mary Swift</i> |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)<br><i>No</i>  |  |  | 16b. SOCIAL SECURITY NO.<br><i>013-26-7056</i>                  |   | 17. INFORMANT<br><i>Julian A. Kerner</i> |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i><br><i>437.9</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Cerebral Arteriosclerosis</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 YRS</i><br><i>4 YRS</i> |  |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>331X</i>   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?             |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                           |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>April 1968</i> , to <i>Oct. 13, 1968</i> , that (I) (we) lost the deceased alive on <i>Oct. 12, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><i>R.T. Benack</i>   |  |  |   | DEGREE<br><i>MD</i>   |  | 22c. DATE SIGNED<br><i>10/13/68</i>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>R.T. Benack MD</i>  |  |  |   | 22e. ADDRESS<br><i>4115 Colie Drive Wheaton, MD</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>   |  | 23b. DATE<br><i>10/16/68</i>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>St John's CEMETERY</i>   |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Worcester Worcester Mass</i> |  |
| 24. FUNERAL DIRECTOR<br><i>Warner E. Pumphrey, Inc.</i>  |  |  |   | 25a. REC'D BY REGISTRAR<br>DATE<br><i>OCT 16 1968</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                               |  |

14703

14703



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 10 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |  |   |   |  |  |  |
|---|--|---|--|--|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |  |   |   |  |  |  |
| CERTIFICATE OF DEATH  |  |   |  |  |   |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><b>Anna McCluskey</b>  |  |   |  |  | 2a. DATE OF DEATH<br>Month Day Year<br><b>10 29 68</b>                            |   |  | 2b. HOUR<br><b>2 30 PM</b>                             |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>white</b>   |  | 5. DATE OF BIRTH<br><b>9-2-92</b>  |   | 6. AGE (In years lost birthday)<br><b>76 YRS.</b>                                 |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.                                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Washington Sanitarium-Hospital</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Housewife</b>  |   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>MONT.</b>   |  | 13c. CITY OR TOWN<br><b>Derwood</b>  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><b>7621 Wardler Lane</b>     |  |
| 14. FATHER'S NAME First Middle Last<br><b>Patrick Prendergast</b>   |  |   |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Bridget Battle</b>               |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>Unknown</b>  |  | 17. INFORMANT Address<br><b>Records - Washington Sanitarium-Hospital</b>   |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Vascular accident, acute, recurrent 3 days</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Suspected Cerebral hemorrhage 3 days</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertensive Cerebrovascular disease years</b><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. <b>331X</b> |  |   |  |  |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Generalized arteriosclerosis, Chronic cholelithiasis</b>  |  |   |  |  |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 13, 1968</b> , to <b>Oct 29, 1968</b> , that (I) (we) last saw the deceased alive on <b>10-28-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. <b>(Viewed by House doctor)</b>  |  |   |  |  |   |   |  |  |  |
| 22b. SIGNATURE<br><b>John R. Spencer, M.D.</b>  |  |   |  |  | 22c. DATE SIGNED<br><b>10-29-68</b>   |   | 22d. PHYSICIAN'S NAME (Type)<br><b>JOHN R. SPENCER</b>               |  |  |
| 22e. ADDRESS<br><b>BURTONSVILLE, M.D.</b>   |  |   |  |  |   |   |  |  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>1012-1968</b>  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Laurel Crest Cemetery, Laurel, Md.</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Laurel, Md.</b>               |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Arthur Walter, 254 Carroll Park, Wash. D.C.</b>  |  |   |  |  | 25a. REC'D BY REGISTRAR<br><b>NOV 1 1968</b>                                      |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 14699  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                             |  | DEPARTMENT OF HEALTH  |  | 14707  |  |
| Item #1, Film G405 10/18/68 km   |  | CERTIFICATE OF DEATH  |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)<br>Charles HARRY   |  | First AKA- C. Harry Middle McClaskey Last   |  | 2a. DATE OF DEATH<br>Month Day Year<br>October 14 1968  |  | 2b. HOUR<br>8 1/2 M  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>March 1, 1892   |  | 6. AGE (In years last birthday)<br>76 YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Philadelphia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Montgomery Md.   |  |
| 10. CITY OR TOWN OF DEATH<br>Wiley   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Brooke Grove Foundation |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Construction   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland  |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Wheatwood  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br>7621 Warbler Lane  |  | 14. FATHER'S NAME<br>First Middle Last<br>Charles H. McClaskey  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Ellen Esther Jenkins   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.<br>179-12-7502   |  | 17. INFORMANT<br>Mrs. Patrick Laid, Randolph Mass.<br>(Daughter)  |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4120<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Bacteria<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Chronic Obstructive Pulmonary Disease<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>442x |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4M.<br>2wk<br>yes                                       |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/25, 1968, to 10/14, 1968, that (I) (no) last saw the deceased alive on 10/12, 1968, and that it is (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  | 22b. SIGNATURE<br>C.H. LIAIN, MD.   |  | 22c. DATE SIGNED<br>10/14/68  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS<br>SANDY SPRING, MD.   |  | 22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE<br>10/17/68   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>LAWN CROFT  |  | 23d. LOCATION (City or Town) (County) (State)<br>BOOTHWEN PA.                        |  |
| 24. FUNERAL DIRECTOR<br>CARR FUNERAL HOME  |  | 24a. SEC'D BY REGISTRAR<br>DATE OCT 16 1968   |  | 24b. REGISTRAR'S SIGNATURE<br>Charles Judge   |  |  |  |



14704

OFFICE OF CLERK

Exhibits  
Admitted  
March 19-1914  
J. H. [illegible]

10/14/14  
J. H. [illegible]

10/14/14

10/14/14  
J. H. [illegible]

10/14/14  
J. H. [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |   |  |  |
|---|--|--|--|--|--|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |   |  |  |
| 14700 CERTIFICATE OF DEATH 14708  |  |  |  |  |  |   |   |  |  |
| 1. DECEASED-NAME (Type or print)  |  |  | First  | Middle   | Last   | 2a. DATE OF DEATH   |   |  | 2b. HOUR                                     |
| David L Mc Cutcherson   |  |  |  |  |  | Month Day Year 10-14-68   |   |  | M  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |  |
| M   |  | W  |  | May 26 1897  |  | 71 YRS.   |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |   |  | Md.  |
| Cal   |  | U S  |  |  |  | Montg   |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY                      |  |
| Wheaton   |  |  | Residence  |  |  | Retired   |   | Police   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                    |  | 13e. STREET AND NUMBER                       |
| 10820 La Rue  |  |  | Montg  |  | Wheaton  |   | YES   |  | 10820 La Rue Wheaton                         |
| 14. FATHER'S NAME   |  |  | First  | Middle   | Last   | 15. MOTHER'S MAIDEN NAME  |   |  | First Middle Last                            |
| David Mc Cutcherson   |  |  |  |  |  | Ellen Mc Cutcherson   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |   |   | Address  |  |
| Yes, no, or unknown   |  |  | 4211   |  | Mrs Rose Mc Cutcherson   |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |   |  |  |
| IMMEDIATE CAUSE (a) Coronary thrombosis   |  |  |  |  |  |   |   |  | 8 hrs  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |   |  |  |
| (b) Coronary atherosclerosis  |  |  |  |  |  |   |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |   |  |  |
| (c) Generalized atherosclerosis   |  |  |  |  |  |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |   |  |  |
| 4201  |  |  |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |
|   |  |  |  |  |  |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |   |  |  |
|   |  |  |  |  |  |   |   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town  |   | County State   |  |
|   |  |  |  |  |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from MAY 15 1968, to 10/14, 1968, that (I) (we) lost saw the deceased alive on OCT 9 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |   |  |  |
| 22b. SIGNATURE  |  |  |  |  | DEGREE   |   | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22c. DATE SIGNED                             |
| Benne H. Buden MD   |  |  |  |  |  |   |   |  | 10-14-68                                     |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  |  | 22e. ADDRESS   |   |   |  |  |
|   |  |  |  |  |  |   |   |  |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |   |  |  |
| 10/17/68  |  | 10/17/68   |  | cedar Hill Cem   |  | La Rue Co Md  |   |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  | ADDRESS  |   | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE                   |
| Mr Hunterman & Son  |  |  |  |  | 5732 La Rue  |   | OCT 18 1968   |  | Charles Judge                                |

80741

700 11

OCT 18 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-4  
30M REV. 1-78

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |   |  |  |                                   |                        |                      |  |
|---|--|--|--|--|---|--|--|-----------------------------------|------------------------|----------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |   |  |  |                                   |                        |                      |  |
| 14701 14709   |  |  |  |  |   |  |  |                                   |                        |                      |  |
| CERTIFICATE OF DEATH  |  |  |  |  |   |  |  |                                   |                        |                      |  |
| 1. DECEASED-NAME<br>(Type or print)   |  |  | First <i>Myrtle</i> Middle <i>Ester</i> Last <i>McGaha</i>                   |  |   | 2a. DATE OF DEATH  |  | 2b. HOUR                          |                        |                      |  |
|   |  |  |  |  |   | Oct Month 14 Day   |  | Year 68 458 M                     |                        |                      |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)  |  | IF UNDER 1 YEAR                   |                        |                      |  |
| F   |  | W  |  | Oct 27-1898  |   | 69 YRS.  |  | MONTHS DAYS HOURS MIN             |                        |                      |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH   |  | Md.                               |                        |                      |  |
| Md.   |  | U.S.   |  |  |   | Montgomery   |  |                                   |                        |                      |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                |  | 12b. KIND OF BUSINESS OR INDUSTRY |                        |                      |  |
| Rockville   |  |  | 916 Grandin Avenue   |  |   | Housewife  |  |                                   |                        |                      |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER |                      |  |
| Md  |  |  | Mont.  |  | Rockville   |  | YES  |                                   | 916 Grandin            |                      |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) |  | 16b. SOCIAL SECURITY NO.          |                        | 17. INFORMANT        |  |
| Harry   |  |  | Riley  |  |   | No   |  | 217-405-9507B                     |                        | Howard McGaha - Same |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  | PART I. DEATH WAS CAUSED BY:   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                                   |                        |                      |  |
| 2001  |  |  | IMMEDIATE CAUSE (a) Pneumonia  |  |   | 24 hrs.  |  |                                   |                        |                      |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  | (b) Lymphosarcoma  |  |   | 8 years  |  |                                   |                        |                      |  |
|   |  |  | (c)  |  |   |  |  |                                   |                        |                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |   |  |  |                                   |                        |                      |  |
| 2001  |  |  |  |  |   |  |  |                                   |                        |                      |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |                        |                      |  |
|   |  |  |  |  |   |  |  |                                   |                        |                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |                                   |                        |                      |  |
|   |  | HOUR A.M. Month Day Year   |  |  |   |  |  |                                   |                        |                      |  |
|   |  | P.M. 19  |  |  |   |  |  |                                   |                        |                      |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |   |  |  |                                   |                        |                      |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  | Street or R.F.D. No. City or Town County State   |   |  |  |                                   |                        |                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1963, to Oct 1968, that (I) (we) last saw the deceased alive on Oct 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |  |  |                                   |                        |                      |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |   | 22c. DATE SIGNED   |  |                                   |                        |                      |  |
| James W. Egan M.D.  |  |  |  |  |   | Oct 14-68  |  |                                   |                        |                      |  |
| 22d. PHYSICIAN'S NAME (Type)  |  | JAMES W. EGAN  |  | 22e. ADDRESS   |   | 5413 Cedar Lane-Bethesda   |  |                                   |                        |                      |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)  |  |                                   |                        |                      |  |
| Burial  |  | 10-17-68   |  | Rockville Cemetery   |   | Rockville, Maryland  |  |                                   |                        |                      |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |  |                                   |                        |                      |  |
| ROBERT A. PUMPHREY, Bethesda, Maryland  |  |  |  | DATE OCT 21 1968   |   | J. Charles Judge   |  |                                   |                        |                      |  |

559

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

14702

## CERTIFICATE OF DEATH

14710

|  |  |   |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) First Middle Last<br><u>Joseph M McMahon</u>   |  |   | 2a. DATE OF DEATH<br>Month Day Year<br><u>10 17 1968</u> |   |  | 2b. HOUR<br><u>11:50</u> M  |  |  |  |  |  |
| 3. SEX<br><u>Male</u>  |  | 4. RACE<br><u>White</u>   |  | 5. DATE OF BIRTH<br><u>6/11/99</u>  |  | 6. AGE (In years<br>lost birthday)<br><u>69</u> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 8. IF UNDER 24 HRS.<br>HOURS MIN.                                |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br><u>New York</u>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><u>U. S.</u>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><u>Montgomery County Md.</u>  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><u>Silver Spring</u>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br><u>Holy Cross Hospital</u> |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired)<br><u>Contractor-Plumbing &amp; Heating</u>                       |  |   |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                     |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br><u>Maryland</u>  |  | 13b. COUNTY<br><u>Montgomery</u>  |  | 13c. CITY OR TOWN<br><u>Kensington</u>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br><u>10600 St. Paul Street</u>                   |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><u>John M. McMahon</u>  |  |   |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><u>Mary King</u>  |  |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <u>No</u>   |  | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br><u>220-01-5717</u>                       |  | 17. INFORMANT<br><u>Daughter</u><br><u>Elizabeth McMahon</u>  |  |   |  | Address<br>Same as Item 13.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart failure</u><br><u>492X</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Cor pulmonale</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Left pneumonectomy with emphysema</u><br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>3 hrs.</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br><u>5271</u>   |  |   |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH?  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <u>19</u>   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)   |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,<br>OFFICE BUILDING, ETC.)                               |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County   |  | State  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 15, 1968</u> , to <u>Oct 17, 1968</u> , that (I) (we) last<br>saw the deceased alive on <u>Oct 17, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><u>Robert T. Thibadeau</u>   |  | 22c. DATE SIGNED<br><u>Oct 17 1968</u>  |  | 22d. PHYSICIAN'S<br>NAME (Type) <u>ROBERT T. THIBADEAU</u>  |  |   |  |  |  |  |  |
| 22e. ADDRESS<br><u>1100 OLD GEORGETOWN RD.</u>   |  | 22f. CITY<br><u>ROLVILLE MD.</u>  |  | 22g. STATE<br><u>20852</u>  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE<br><u>10-21-68</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Andrews Chapel Cem.</u>  |  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Vienna, Virginia</u> |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>  |  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>OCT 24 1968</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |  |  |  |



14710

RECEIVED

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230-01-0111 Elizabethan  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to the Registrar, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14703

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14711

|  |  |  |   |   |  |  |  |   |  |   |  |
|--|--|--|---|---|--|--|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) Elizabeth A. McKenna   |  |  | 2a. DATE OF DEATH<br>Oct. 18 Day 1968   |   |  | 2b. HOUR<br>10:00 AM   |  |   |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White                       |   | 5. DATE OF BIRTH<br>Sept. 16 1889   |  | 6. AGE (In years last birthday)<br>79 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN |  |   |  |
| 7a. BIRTHPLACE (State or foreign country)<br>New York  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Montgomery Md.   |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>6115 Wynnwood Rd. |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>Housewife |  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE N.Y.   |  |  | 13b. COUNTY<br>V  |   |  | 13c. CITY OR TOWN<br>New Rochelle  |  | 13d. INSIDE CITY LIMITS?<br>NO <input type="checkbox"/>         |  | 13e. STREET AND NUMBER<br>142 Bonair Ave. |  |
| 14. FATHER'S NAME<br>Theodore J Ellenbast  |  |  | 15. MOTHER'S MAIDEN NAME<br>Catherine ?   |   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown) NO   |  |  | 16b. SOCIAL SECURITY NO.  |   |  | 17. INFORMANT<br>Rita A Ferguson Daughter  |  |   | Address #11  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>342x Congestive heart failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Parkinson's disease</u> |  |  |   |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 months</u><br><u>3 years</u><br><u>1 year</u> |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>350x</u>  |  |  |   |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                               |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                      |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                      |   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/17</u> , 19 <u>68</u> , to <u>10/16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10/16</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><u>Dr Joseph P. Kenrick</u>  |  |  | DEGREE<br>ATTENDING PHYS.   |   |  | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.               |  |   | 22c. DATE SIGNED<br><u>10/18/68</u>  |   |  |
| 22d. PHYSICIAN'S NAME (Type)<br><u>DR JOSEPH P. KENRICK</u>  |  |  | 22e. ADDRESS<br><u>6450 Wisconsin Ave, Bethesda, Md.</u>  |   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  |  | 23b. DATE<br><u>10/22/68</u>  |   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Gate of Heaven Cem.</u>                                     |  |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Valhalla N.Y.</u>                              |   |  |
| 24. FUNERAL DIRECTOR<br><u>Robert A. DeVol</u>   |  |  | ADDRESS<br><u>Washington D.C.</u>   |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>OCT 21 1968</u>   |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   |  |

14511

UNITED STATES DEPARTMENT OF JUSTICE

14511

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |   |  |  |   |   |
|--|--|--|--|---|---|--|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |   |   |  |  |   |   |
| CERTIFICATE OF DEATH   |  |  |  |   |   |  |  |   |   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>MONTGOMERY</u> MARYLAND  |  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> |  |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>KENSINGTON</u>  |  |  | c. LENGTH OF STAY IN lb<br><u>15 YEARS</u> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>KENSINGTON</u>   |  |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>11021 MADISON ST KENSINGTON</u>   |  |  |  |   | d. STREET ADDRESS<br><u>11021 MADISON ST</u>  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>JAMES EDWARD MEDLAR</u>  |  |  |  |   | 4. DATE OF DEATH<br>Month <u>OCTOBER</u> Day <u>1</u> Year <u>1968</u>  |  |  |   |   |
| 5. SEX<br><u>MALE</u>  |  | 6. COLOR OR RACE<br><u>CAUC</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>SEPT 16, 1908</u>           |  | 9. AGE (In years lost birthday) <u>60</u> yrs.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>PLANT PLANNING</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>GOVT PRINTING OFFICE</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>BURLINGTON, VT</u>  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                         |   |   |
| 13. FATHER'S NAME<br><u>JOHN MEDLAR</u>  |  |  |  |   | 14. MOTHER'S MAIDEN NAME<br><u>MASEL BROWN</u>  |  |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>YES</u>  |  | 16. SOCIAL SECURITY NO.<br><u>511843-7111845</u>   |  | 17. INFORMANT<br><u>WIFE</u>  |   |  | Address <u>KENSINGTON</u><br><u>YVETTE MEDLAR 11021 MADISON ST</u> |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u><br>DUE TO <u>4100</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSION AND DIABETES</u><br>DUE TO <u>6 YEARS</u><br>(c) |  |  |  |   |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 MINS</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>4201</u> <u>NOTE</u>  |  |  |  |   |   |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><u>NO</u>  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>---</u>  |   |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <u>---</u> 19 <u>---</u><br>p.m. <u>---</u>  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>---</u>  |   | 20f. (City or town) (County) (State)<br><u>---</u> |  |   |   |
| 21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>MID</u> , 19 <u>64</u> , to <u>1 OCTOBER 1968</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>25 JULY 1968</u> , and that death occurred at <u>10:00 A.M.</u> , from causes and on the date stated above.  |  |  |  |   |   |  |  |   |   |
| 22a. SIGNATURE<br><u>Frederick S Caldwell</u>  |  |  |  |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>          |  |  | 22b. DATE SIGNED<br><u>1 OCT 1968</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>FREDERICK S CALDWELL</u>  |  |  |  |   | 22d. ADDRESS<br><u>TENNEY BLDG ROCKVILLE MARYLAND</u>   |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  | 23b. DATE THEREOF<br><u>10/4/68</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Gate of Heaven Cemetery, Silver Spg. Montg. Md.</u>  |   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>---</u>        |   |   |
| 24. FUNERAL DIRECTOR<br><u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>  |  |  |  |   | 25a. REC'D BY REGISTRAR<br><u>DATE OCT 2 1968</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>J Charles Judge</u>               |   |   |

18712

RECEIVED

18712

*[Faint, mostly illegible text and markings, possibly a receipt or ledger entry, with some handwritten notes.]*

1888

1888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14703

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14713

CERTIFICATE OF DEATH

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Anna</i> First <i>Mehler</i> Middle Last   |  |  | 2a. DATE OF DEATH<br>Month <i>10</i> Day <i>9</i> Year <i>68</i> |  |  | 2b. HOUR <i>2</i> MIN <i>5</i>   |  |
| 3. SEX <i>Female</i>  |  | 4. RACE <i>White</i>   |  | 5. DATE OF BIRTH<br><i>12-6-1876</i>   |  | 6. AGE (In years last birthday) <i>91</i> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>   |  | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <i>Montgomery</i> Md.   |  |
| 10. CITY OR TOWN OF DEATH <i>Bethesda</i>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Suburban</i> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Homemaker</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>  |  | 13b. COUNTY <i>Mont.</i>   |  | 13c. CITY OR TOWN <i>Chevy Chase</i>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME <i>William H. Lipscomb</i> First Middle Last  |  | 15. MOTHER'S MAIDEN NAME <i>Anna Rahiegh</i> First Middle Last                               |  | 13e. STREET AND NUMBER <i>3 Fairfax Court</i>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>   |  | 16b. SOCIAL SECURITY NO. <i>219-54-7466</i>  |  | 17. INFORMANT <i>Mrs. Dorothy Riviere-Daughte</i> Address  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>ADENOCARCINOMA, COLON, WITH METASTASES</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>ARTERIOSCLEROTIC HEART DISEASE WITH CONGEST. FAILURE</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>ARTERIAL OCCLUSION, RIGHT FOOT ARTERIOSCLEROTIC</i><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>1538</i> |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 yr.</i><br><i>6 mo.</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <i>9-25-68</i>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>ADENOCARCINOMA OF COLON</i>              |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>                            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                 |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1965</i> , to <i>OCT 9, 1968</i> , that (I) (we) last saw the deceased alive on <i>OCT 9, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |
| 22b. SIGNATURE <i>Leo M. Curtis M.D.</i>  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                          |  | 22c. DATE SIGNED <i>10-9-68</i>  |  |
| 22d. PHYSICIAN'S NAME (Type) <i>LEO M. CURTIS, M.D.</i>   |  |  |  | 22e. ADDRESS <i>8218 WISCONSIN AVE, BETHESDA, MONT., MD.</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |  | 23b. DATE <i>10/12/68</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>  |  | 23d. LOCATION (City or Town) (County) (State) <i>Suitland, Pr. Geo. Md.</i>                  |  |
| 24. FUNERAL DIRECTOR <i>ROBERT A. PUMPHREY, Bethesda, Mary.</i>   |  |  |  | 25a. REC'D BY REGISTRAR <i>Charles Judge</i>   |  | 25b. REGISTRAR'S SIGNATURE   |  |

15713

MINUTIA OF UTAH

10/12/08

(M)

OWN HOME

BOONVILLE

212-44-400

10

(1)

10/12/08 Cedar Hill Cemetery, Springfield, Ill. Co. 10.  
7837 "Lancaster Ave." OCT 14 1908  
10/12/08 Cedar Hill Cemetery, Springfield, Ill. Co. 10.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14706

14714

CERTIFICATE OF DEATH

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED-NAME<br>(Type or print)<br>First Middle Last<br>Mary Frances MELENDEZ  |  |   | 2a. DATE OF DEATH<br>Month Day Year<br>4 October 1968           |   | 2b. HOUR<br>8:08 PM   |
| 3. SEX<br>Female   |  | 4. RACE<br>Cauc   | 5. DATE OF BIRTH<br>4 October 1968                              |   | 6. AGE (In years last birthday)<br>YRS. MONTHS DAYS<br>2 47 |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>America   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 9. COUNTY OF DEATH<br>Montgomery   |  | Md.   |   |   |   |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>Naval Hospital  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>N/A  |   |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>N/A   |  |   |   |   |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Virginia  |  | 13b. CITY OR TOWN<br>Arlington  |   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 13d. STREET AND NUMBER<br>112 S. Court House Rd.   |  |   |   |   |   |
| 14. FATHER'S NAME<br>First Middle Last<br>George C. MELENDEZ   |  |   | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Margaret PRADO |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>N/A   |   | 17. INFORMANT<br>112 S. Court House Rd.<br>George C. MELENDEZ Arlington, Virginia   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Prematurty, 2500 Grams, Female<br>7769<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Atelectasis, Bilateral<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)<br>7625  |  |   |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>Yes  |  |   |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |   |
| 22a. I certify that (X) (this hospital) attended the deceased from 4 October, 1968, to 4 October, 1968, that (X) (we) last saw the deceased alive on 4 October 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.   |  |   |   |   |   |
| 22b. SIGNATURE<br>J. G. FLEMING  |  | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>6 October 1968  |   |
| 22d. PHYSICIAN'S NAME (Type)<br>J. G. FLEMING  |  | 22e. ADDRESS<br>Naval Hospital, Bethesda, Maryland  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE<br>10/8/68  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National Cemetery   |   |
| 23d. LOCATION (City or Town) (County) (State)<br>Arlington, Va.  |  |   |   |   |   |
| 24. FUNERAL DIRECTOR<br>Taltavull Funeral Home<br>4748 Wisconsin Ave. N.W. Washington, D.C.  |  | 25a. REC'D BY REGISTRAR<br>DATE OCT 8 1968  |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge   |   |

|   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |    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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 | 1001 | 1002 | 1003 | 1004 | 1005 | 1006 | 1007 | 1008 | 1009 | 1010 | 1011 | 1012 | 1013 | 1014 | 1015 | 1016 | 1017 | 1018 | 1019 | 1020 | 1021 | 1022 | 1023 | 1024 | 1025 | 1026 | 1027 | 1028 | 1029 | 1030 | 1031 | 1032 | 1033 | 1034 | 1035 | 1036 | 1037 | 1038 | 1039 | 1040 | 1041 | 1042 | 1043 | 1044 | 1045 | 1046 | 1047 | 1048 | 1049 | 1050 | 1051 | 1052 | 1053 | 1054 | 1055 | 1056 | 1057 | 1058 | 1059 | 1060 | 1061 | 1062 | 1063 | 1064 | 1065 | 1066 | 1067 | 1068 | 1069 | 1070 | 1071 | 1072 | 1073 | 1074 | 1075 | 1076 | 1077 | 1078 | 1079 | 1080 | 1081 | 1082 | 1083 | 1084 | 1085 | 1086 | 1087 | 1088 | 1089 | 1090 | 1091 | 1092 | 1093 | 1094 | 1095 | 1096 | 1097 | 1098 | 1099 | 1100 | 1101 | 1102 | 1103 | 1104 | 1105 | 1106 | 1107 | 1108 | 1109 | 1110 | 1111 | 1112 | 1113 | 1114 | 1115 | 1116 | 1117 | 1118 | 1119 | 1120 | 1121 | 1122 | 1123 | 1124 | 1125 | 1126 | 1127 | 1128 | 1129 | 1130 | 1131 | 1132 | 1133 | 1134 | 1135 | 1136 | 1137 | 1138 | 1139 | 1140 | 1141 | 1142 | 1143 | 1144 | 1145 | 1146 | 1147 | 1148 | 1149 | 1150 | 1151 | 1152 | 1153 | 1154 | 1155 | 1156 | 1157 | 1158 | 1159 | 1160 | 1161 | 1162 | 1163 | 1164 | 1165 | 1166 | 1167 | 1168 | 1169 | 1170 | 1171 | 1172 | 1173 | 1174 | 1175 | 1176 | 1177 | 1178 | 1179 | 1180 | 1181 | 1182 | 1183 | 1184 | 1185 | 1186 | 1187 | 1188 | 1189 | 1190 | 1191 | 1192 | 1193 | 1194 | 1195 | 1196 | 1197 | 1198 | 1199 | 1200 | 1201 | 1202 | 1203 | 1204 | 1205 | 1206 | 1207 | 1208 | 1209 | 1210 | 1211 | 1212 | 1213 | 1214 | 1215 | 1216 | 1217 | 1218 | 1219 | 1220 | 1221 | 1222 | 1223 | 1224 | 1225 | 1226 | 1227 | 1228 | 1229 | 1230 | 1231 | 1232 | 1233 | 1234 | 1235 | 1236 | 1237 | 1238 | 1239 | 1240 | 1241 | 1242 | 1243 | 1244 | 1245 | 1246 | 1247 | 1248 | 1249 | 1250 | 1251 | 1252 | 1253 | 1254 | 1255 | 1256 | 1257 | 1258 | 1259 | 1260 | 1261 | 1262 | 1263 | 1264 | 1265 | 1266 | 1267 | 1268 | 1269 | 1270 | 1271 | 1272 | 1273 | 1274 | 1275 | 1276 | 1277 | 1278 | 1279 | 1280 | 1281 | 1282 | 1283 | 1284 | 1285 | 1286 | 1287 | 1288 | 1289 | 1290 | 1291 | 1292 | 1293 | 1294 | 1295 | 1296 | 1297 | 1298 | 1299 | 1300 | 1301 | 1302 | 1303 | 1304 | 1305 | 1306 | 1307 | 1308 | 1309 | 1310 | 1311 | 1312 | 1313 | 1314 | 1315 | 1316 | 1317 | 1318 | 1319 | 1320 | 1321 | 1322 | 1323 | 1324 | 1325 | 1326 | 1327 | 1328 | 1329 | 1330 | 1331 | 1332 | 1333 | 1334 | 1335 | 1336 | 1337 | 1338 | 1339 | 1340 | 1341 | 1342 | 1343 | 1344 | 1345 | 1346 | 1347 | 1348 | 1349 | 1350 | 1351 | 1352 | 1353 | 1354 | 1355 | 1356 | 1357 | 1358 | 1359 | 1360 | 1361 | 1362 | 1363 | 1364 | 1365 | 1366 | 1367 | 1368 | 1369 | 1370 | 1371 | 1372 | 1373 | 1374 | 1375 | 1376 | 1377 | 1378 | 1379 | 1380 | 1381 | 1382 | 1383 | 1384 | 1385 | 1386 | 1387 | 1388 | 1389 | 1390 | 1391 | 1392 | 1393 | 1394 | 1395 | 1396 | 1397 | 1398 | 1399 | 1400 | 1401 | 1402 | 1403 | 1404 | 1405 | 1406 | 1407 | 1408 | 1409 | 1410 | 1411 | 1412 | 1413 | 1414 | 1415 | 1416 | 1417 | 1418 | 1419 | 1420 | 1421 | 1422 | 1423 | 1424 | 1425 | 1426 | 1427 | 1428 | 1429 | 1430 | 1431 | 1432 | 1433 | 1434 | 1435 | 1436 | 1437 | 1438 | 1439 | 1440 | 1441 | 1442 | 1443 | 1444 | 1445 | 1446 | 1447 | 1448 | 1449 | 1450 | 1451 | 1452 | 1453 | 1454 | 1455 | 1456 | 1457 | 1458 | 1459 | 1460 | 1461 | 1462 | 1463 | 1464 | 1465 | 1466 | 1467 | 1468 | 1469 | 1470 | 1471 | 1472 | 1473 | 1474 | 1475 | 1476 | 1477 | 1478 | 1479 | 1480 | 1481 | 148 |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14707

CERTIFICATE OF DEATH

14715

|   |   |  |  |   |  |
|---|---|--|--|---|--|
| 1. DECEASED-NAME<br>(Type or print) <i>LA Rue W. Melendy</i>  |   |  | 2a. DATE OF DEATH<br><i>Oct</i> Month <i>17</i> Day <i>1968</i> Year                 |   | 2b. HOUR<br><i>105 P</i>   |
| 3. SEX<br><i>male</i>   | 4. RACE<br><i>white</i>   | 5. DATE OF BIRTH<br><i>7-5-1985</i>  |  | 6. AGE (In years last birthday)<br><i>82</i> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Mich.</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><i>Montgomery County</i> Md.                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring, Md.</i>  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Colonial Village</i> | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><i>Montgomery</i>               | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Maryland</i>  | 13b. COUNTY<br><i>MONT.</i>   | 13c. CITY OR TOWN<br><i>Burtonsville</i>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER<br><i>3409 Greenbelt Rd.</i> |  |
| 14. FATHER'S NAME<br>First <i>Bryant</i> Middle <i>A.</i> Last <i>Melendy</i>   | 15. MOTHER'S MAIDEN NAME<br>First <i>Sarah</i> Middle <i>Smith</i> Last <i>Smith</i>                    |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown                  |   |  |
| 16b. SOCIAL SECURITY NO.<br><i>56-44-6570 A</i>   |   | 17. INFORMANT<br><i>Residence Melendy</i>  |  | Address<br><i>15450 Bannock Rd.</i>                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Pulmonary Edema</i><br><i>4129</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Arteriosclerotic Heart Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>4200 Cerebral Thromboses</i>   |   |  |  |   |  |
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |   |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>                                       | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            | 21f. LOCATION Street or R.F.D. No.   | City or Town   | County  | State  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 19 <i>65</i> , to <i>Oct.</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Oct 15</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |  |  |   |  |
| 22b. SIGNATURE<br><i>Joseph E. Smith Jr. M.D.</i>   |   | DEGREE<br><i>M.D.</i>  | ATTENDING PHYS.<br><input checked="" type="checkbox"/>                               | MED. DIRECTOR <input type="checkbox"/>              | STAFF PHYS. <input type="checkbox"/>                             |
| 22d. PHYSICIAN'S NAME (Type)<br><i>Joseph E. Smith Jr.</i>  |   | 22c. DATE SIGNED   |  |   |  |
| 22e. ADDRESS<br><i>Burtonsville, Md.</i>  |   |  |  |   |  |
| 23a. BURIAL-CREMATATION, REMOVAL (Specify)  | 23b. DATE<br><i>Oct. 21-1968</i>  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Lee-High</i>  |  | 23d. LOCATION (City or Town)<br><i>Rockville</i>    | (County)<br><i>Mont.</i> (State)<br><i>Md.</i>                   |
| 24. FUNERAL DIRECTOR<br><i>Arthur Waters</i>  |   | ADDRESS<br><i>254 Carroll St. N.W. Washington, D.C. 20012</i>  |  | 25a. REC'D BY REGISTRAR<br><i>Oct 21 1968</i>       | 25b. REGISTRAR'S SIGNATURE<br><i>James J. Judge</i>              |

1912

RECEIVED OF DEAN

*[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |                                   |  |  |
|---|--|--|--|--|--|---|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |   |  |                                   |  |  |
| CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |                                   |  |  |
| 1. DECEASED NAME<br>(Type or print)   |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |  | 2b. HOUR                          |  |  |
| Charles Joseph Merrill  |  |  |  |  |  | October 7 1968  |  | 10:30 AM                          |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR                   |  |  |
| Male  |  | White  |  | 28 September 1943  |  | 25 YRS.   |  | MONTHS DAYS HOURS MIN.            |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |                                   |  |  |
| New York  |  | USA  |  |  |  | Montgomery Md.  |  |                                   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |
| Bethesda  |  |  | The Clinical Center, NIH   |  |  | Clerk   |  | Rental Agency                     |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                   | 13e. STREET AND NUMBER                       |  |
| New York  |  |  |  |  | Zone Park  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                          |                                   | 9459 Plattwood Avenue                        |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  |   |  |                                   |  |  |
| First Middle Last   |  |  | First Middle Last  |  |  |   |  |                                   |  |  |
| Arthur Merrill  |  |  | Charlotte Arnold   |  |  |   |  |                                   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |   |  |                                   |  |  |
| No  |  |  | Not Available  |  | Bethesda, Maryland Address The Medical Records, The Clinical Center, |   |  |                                   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |  |  |  |   |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  |   |  |                                   |  |  |
| IMMEDIATE CAUSE (a) Right lower lobe pneumonia  |  |  |  |  |  |   |  |                                   | 2 weeks                                      |  |
| 2040 DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |  |   |  |                                   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |  |  |  |  |  |   |  |                                   |  |  |
| (b) Acute lymphocytic leukemia  |  |  |  |  |  |   |  |                                   | 5 years                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |                                   |  |  |
| (c)   |  |  |  |  |  |   |  |                                   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |   |  |                                   |  |  |
| 2043  |  |  |  |  |  |   |  |                                   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |                                   |  |  |
|   |  |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | Yes  |                                   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |                                   |  |  |
|   |  | HOUR A.M. Month Day Year P.M. 19   |  |  |  |   |  |                                   |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |  | Street or R.F.D. No.  |  | City or Town County State         |  |  |
|   |  |  |  |  |  |   |  |                                   |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from 3 Sept. 1968, to 7 October, 1968, that (X) (we) last saw the deceased alive on 7 October 1968, and that in (M) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (do not) view the body after death. |  |  |  |  |  |   |  |                                   |  |  |
| 22b. SIGNATURE  |  |  |  | 22c. DATE SIGNED   |  |   |  |                                   |  |  |
| Edward S. Henderson M.D.  |  |  |  | 7 October 1968   |  |   |  |                                   |  |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |  |  | 22e. ADDRESS   |  |   |  |                                   |  |  |
| Edward S. Henderson, M. D.  |  |  |  | The Clinical Center, National Institutes of Health, Bethesda, Md.  |  |   |  |                                   |  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |                                   |  |  |
| Burial  |  | 10-10-68   |  |  |  | New York City, NY   |  |                                   |  |  |
| 24. PHYSICIAN DIRECTOR  |  |  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE        |  |  |
| W.W. Chambers G   |  |  |  | 1400 Chapin St NW  |  | OCT 10 1968   |  | Charles Judge                     |  |  |

14718

RECEIVED

10

(M)

(1)

100



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| 1. DECEASED-NAME<br>(Type or Print)  |  |  |  |  |  |   |  |  |  | 2a. DATE KNOWN OF DEATH  |  | 2b. HOUR   |  |          |  |
|--|--|--|--|--|--|---|--|--|--|--|--|--|--|----------|--|
| First Middle Last<br>Clara Marie Metes   |  |  |  |  |  |   |  |  |  | ESTIMATED <input checked="" type="checkbox"/> Month Day Year<br>10-11-68 19                  |  | 8 A.M.   |  |          |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)                             |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |  | 2c. DATE PRONOUNCED DEAD   |  | 2d. HOUR |  |
| Fe   |  | W  |  | 6-29-24  |  | 44 YRS.   |  | MONTHS DAYS  |  | HOURS MIN.   |  | Month Oct. Day 11 Year 1968  |  | 9 A.M.   |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. COUNTY OF DEATH   |  |          |  |
| Hungary  |  |  |  | USA  |  |   |  |  |  |  |  | Montgomery Md.   |  |          |  |
| 10. CITY OR TOWN OF DEATH  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |          |  |
| Takoma Park  |  |  |  | Washington San. & Hospital   |  |   |  | Housewife  |  |  |  | own home   |  |          |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  |  | 13b. COUNTY  |  |   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |          |  |
| Md.  |  |  |  | Mont.  |  |   |  | Sil. Spr.  |  |  |  | 402 Lexington Dr.  |  |          |  |
| 14. FATHER'S NAME First Middle Last  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last                  |  |  |  |  |  |  |  |          |  |
| Stephen Nicholas Modly   |  |  |  |  |  | Gizella nmn Tahy  |  |  |  |  |  |  |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  |  |  |  | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT ADDRESS  |  |  |  |  |  |          |  |
| NO   |  |  |  |  |  | 579-42-3852   |  | Mr. Mircea U. Metes 402 Lexington Dr. Sil. Spr. Md.  |  |  |  |  |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |          |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |  |  |  |  |  |  |          |  |
| IMMEDIATE CAUSE (a) <u>Fracture Cervical Spine with Transection.</u>   |  |  |  |  |  |   |  |  |  |  |  |  |  |          |  |
| 816.9 DUE TO, OR AS A CONSEQUENCE OF <u>of Spinal Cord.</u>  |  |  |  |  |  |   |  |  |  |  |  | Soldier.   |  |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Trauma Auto. Accident</u>  |  |  |  |  |  |   |  |  |  |  |  |  |  |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |  |   |  |  |  |  |  |  |  |          |  |
| 8234   |  |  |  |  |  |   |  |  |  |  |  |  |  |          |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |  |  |  |  |  | 21b. TIME OF INJURY Month, Day, Year                        |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |  |  |  |  |          |  |
|  |  |  |  |  |  | 8:45 A.M. 10/11 1968  |  | Car out of control struck utility pole.  |  |  |  |  |  |          |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town  |  | County   |  | State  |  |  |  |          |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | Highway  |  | University Blvd - S. Near Spring   |  | Mont.   |  | Md.  |  |  |  |  |  |          |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |   |  |  |  |  |  |  |  |          |  |
| ACTUAL SIGNATURE <u>John G. Ball</u>   |  |  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>             |  |  |  |  |  | 22b. DATE SIGNED   |  |          |  |
| EXAMINER'S NAME (Type) <u>John G. Ball</u>   |  |  |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>         |  |  |  |  |  | Oct. 11, 1968  |  |          |  |
|  |  |  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |          |  |
|  |  |  |  |  |  | ADDRESS (Street, city, town, or county)                     |  |  |  |  |  |  |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town)                                |  | (County)   |  | (State)  |  |  |  |          |  |
| Burial   |  | 10-15-1968   |  | Gate of Heaven Cemetery  |  | Sil. Spr.   |  | Montg.   |  | Md.  |  |  |  |          |  |
| Funeral Director <u>C. Glen Carter</u>   |  |  |  |  |  | ADDRESS   |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |          |  |
| Warner E. Pumphrey, Inc.   |  |  |  |  |  | 8434 Ga. Ave. S.S., Md.                                     |  | DATE OCT 21 1968   |  | J. Charles Judge   |  |  |  |          |  |

1941

RESEARCH EXAMINER'S CERTIFICATE OF ANALYSIS

DATE  
HEALTH OFFICE



1941

1-1-41

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14710

14718

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                      |  |  |  |  |   |  |   |  |
|--|----------------------|--|--|--|--|---|--|---|--|
| 1. DECEASED-NAME<br>(Type or Print) <u>DONALD</u> <u>CANNEY</u> <u>MITCHELL</u>  |                      |  | 2. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>Oct</u> Day <u>29</u> Year <u>1968</u> |  |  | 2b. HOUR- <u>7:22 PM</u>  |  |   |  |
| 3. SEX <u>MALE</u>   | 4. RACE <u>WHITE</u> | 5. DATE OF BIRTH <u>MAR. 31, 1914</u>  | 6. AGE (In years last birthday) <u>54</u> YRS.   | IF UNDER 1 YEAR<br>MONTHS <u>0</u> DAYS <u>0</u>   | IF UNDER 24 HRS.<br>HOURS <u>0</u> MIN. <u>0</u>                                       | 2c. DATE PRONOUNCED DEAD<br>Month <u>10</u> Day <u>29</u> Year <u>1968</u>        |  |   | 2d. HOUR <u>7:55 PM</u>                      |
| 7a. BIRTHPLACE (State or foreign country) <u>Illinois</u>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <u>Montgomery</u>  |  |   | Md.  |
| 10. CITY OR TOWN OF DEATH <u>Bethesda</u>  |                      | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) |   |  | 12b. KIND OF BUSINESS OR INDUSTRY                           |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u>  |                      | 13b. COUNTY <u>Montgomery</u>  |  | 13c. CITY OR TOWN <u>Bethesda</u>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER <u>APT. 309 4808 WELLINGTON DR.</u>  |  |
| 14. FATHER'S NAME First <u>Joseph J.</u> Middle <u>Mitchell</u> Last <u>Mitchell</u>   |                      |  | 15. MOTHER'S MAIDEN NAME First <u>Louise</u> Middle <u>Canney</u> Last <u>Canney</u>                       |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>U.S. A.</u>   |                      |  | 16b. SOCIAL SECURITY NO. <u>111-22-4775</u>  |  | 17. INFORMANT <u>Robert A. Pumphrey</u> ADDRESS <u>4824 Chevy Chase St.</u>            |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |                      |  |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive gastrointestinal hemorrhage</u>  |                      |  |  |  |  |   |  |   |  |
| 571.0 DUE TO, OR AS A CONSEQUENCE OF Ruptured esophageal varices   |                      |  |  |  |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) <u>Advanced liver cirrhosis, Laennec's type</u>  |                      |  |  |  |  |   |  |   | Years.                                       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |                      |  |  |  |  |   |  |   |  |
| 5811   |                      |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |   | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                      | 21b. TIME OF INJURY Month, Day, Year <u>19</u> A.M. <u>P.M.</u>                              |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                      | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                 |  | 21f. LOCATION Street or R.F.D. No.   |  | City or Town  |  | County  | State  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                      |  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <u>John G. Ball</u>   |                      | EXAMINER'S NAME (Type) <u>John G Ball</u>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                               |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |
|  |                      |  |  | ADDRESS (Street, city, town, or county)  |  | 22b. DATE SIGNED <u>Oct 30, 1968</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                      | 23b. DATE <u>Nov. 1, 68</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>   |  | 23d. LOCATION (City or Town) <u>Baltimore, Maryland</u>                           |  | (County) (State)  |  |
| 24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u>  |                      |  |  | 25a. REC'D BY REGISTRAR <u>NOV 4 1968</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>                                 |  |   |  |

21541

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |                  |  |                                 |  |   | 14719  |  |
|--|--|--|--|--|------------------|--|---------------------------------|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |                  |  |                                 |  |   | 14719  |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |                  |  |                                 |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or Print)  |  |  | First Middle Last  |  |                  | 2a. DATE KNOWN OF DEATH  |                                 |  | 2b. HOUR  |  |  |
| ESTHER BELL MONTGOMERY   |  |  |  |  |                  | Month Day Year   |                                 |  | 2d. HOUR  |  |  |
| 3. SEX   |  |  | 4. RACE  |  | 5. DATE OF BIRTH |  | 6. AGE (In years last birthday) |  | 7c. DATE PRONOUNCED DEAD  |  |  |
| FEMALE   |  |  | WHITE  |  | 3/26/04          |  | 64 YRS.                         |  | Month Day Year  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |                  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                 |  | 9. COUNTY OF DEATH  |  |  |
| MARYLAND   |  |  | U. S. A.   |  |                  |  |                                 |  | MONTGOMERY  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| BETHESDA   |  |  | SUBURBAN   |  |                  | SCHOOL TEACHER   |                                 |  |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |                  | 13c. CITY OR TOWN  |                                 |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| MARYLAND   |  |  | CARROLL  |  |                  | WESTMINSTER  |                                 |  | 13e. STREET AND NUMBER  |  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |                  |  |                                 |  |   |  |  |
| BRADFORD BLIZZARD  |  |  | NANCY  |  |                  |  |                                 |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |  |                  | 17. INFORMANT  |                                 |  | ADDRESS SAME ADDRESS  |  |  |
| NO   |  |  | 220-36-8580  |  |                  | WILLIAM MONTGOMERY - HUSBAND   |                                 |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |                  |  |                                 |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |                  |  |                                 |  |   |  |  |
| IMMEDIATE CAUSE (a) Massive hemorrhage, intra-thorax, left   |  |  |  |  |                  |  |                                 |  |   | Sudden                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |                  |  |                                 |  |   |  |  |
| (b) Ruptured saccular aneurysm, thoracic aorta   |  |  |  |  |                  |  |                                 |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |                  |  |                                 |  |   |  |  |
| (c) Arteriosclerosis, marked.  |  |  |  |  |                  |  |                                 |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |  |                  |  |                                 |  |   |  |  |
| 451X   |  |  |  |  |                  |  |                                 |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |  |                  | 20. AUTOPSY?   |                                 |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  | 21b. TIME OF INJURY Month, Day, Year   |  |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |                                 |  |   |  |  |
|  |  |  | HOUR A.M. P.M. 19  |  |                  |  |                                 |  |   |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  |                  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |                                 |  |   |  |  |
|  |  |  |  |  |                  |  |                                 |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |                  |  |                                 |  |   |  |  |
| ACTUAL SIGNATURE   |  |  | CHIEF MEDICAL EXAMINER   |  |                  | 22b. DATE SIGNED   |                                 |  |   |  |  |
| EXAMINER'S NAME (Type)   |  |  | ASSISTANT MEDICAL EXAMINER   |  |                  | DEPUTY MEDICAL EXAMINER  |                                 |  |   |  |  |
| John E. Ball   |  |  |  |  |                  | OCT - 7, 1968  |                                 |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  | 23b. DATE  |  |                  | 23c. NAME OF CEMETERY OR CREMATORY   |                                 |  | 23d. LOCATION (City or Town) (County) (State)                                     |  |  |
| BURIAL   |  |  | 10/10/68   |  |                  | TRINITY LUTH. CEMETERY   |                                 |  | SMALLWOOD, CARROLL, MD  |  |  |
| 24. FUNERAL DIRECTOR   |  |  | 25a. REC'D BY REGISTRAR  |  |                  | 25b. REGISTRAR'S SIGNATURE   |                                 |  |   |  |  |
| J. S. Myers, Jr., Funeral Director, Inc.   |  |  | OCT 10 1968  |  |                  | Charles Judge  |                                 |  |   |  |  |



14713

MEDICAL EXAMINER - BUREAU OF HEALTH

DIVISION OF HEALTH - DISTRICT OF COLUMBIA

FOR STATE  
HEALTH DEPT

of, x, y, z, w, v, u, t, s, r, q, p, o, n, m, l, k, j, i, h, g, f, e, d, c, b, a

of, x, y, z, w, v, u, t, s, r, q, p, o, n, m, l, k, j, i, h, g, f, e, d, c, b, a

of, x, y, z, w, v, u, t, s, r, q, p, o, n, m, l, k, j, i, h, g, f, e, d, c, b, a

10/10/68  
1000 01 100  
10/10/68



14712

## CERTIFICATE OF DEATH

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>JAMES E. MOONEY</b>  |  |   | 2a. DATE OF DEATH<br><b>10</b> Month <b>27</b> Day <b>68</b> Year |   |  | 2b. HOUR<br><b>11:15</b> AM  |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>   |   | 5. DATE OF BIRTH<br><b>7/30/01</b>  |  | 6. AGE (In years lost birthday)<br><b>67</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>New York</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>Montgomery</b> Md.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Suburban</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>Montgomery</b>  |   | 13c. CITY OR TOWN<br><b>Potomac</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 13e. STREET AND NUMBER<br><b>11201 Judy Place</b>   |  | 14. FATHER'S NAME First Middle Last<br><b>Edward Money</b>                                      |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>Ellen Massey</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) |  |
| 16b. SOCIAL SECURITY NO.<br><b>-</b>  |  | 17. INFORMANT<br><b>Mildred M. Mooney</b>   |   | Address<br><b>Wife - same</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Verdumb F. Abutlation</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic heart disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1/2 hour</b><br><b>4 years</b> |  |   |   |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>4200</b>  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>                               |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                    |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/28</b> , 19 <b>64</b> , to <b>10/27</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/27</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Jack P. Segal</b>  |  |   |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                      |  | 22c. DATE SIGNED<br><b>10/28/68</b>  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>Jack P. Segal, MD</b>  |  |   |   | 22e. ADDRESS<br><b>5323 Conn. Ave NW WASH DC</b>  |  |  |  |
| 23a. BURIAL, CREMATION<br><b>BURIAL</b>   |  | 23b. DATE<br><b>10-30-1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rock Creek Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington, D.C.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons, Inc., 3130 Wisc. Ave. N.W., Wash., D.C., 20016</b>   |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>NOV 4 1968</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-58

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |   |  |   |                            |                  |  |
|--|--|--|--|--|---|---|--|---|----------------------------|------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |   |  |   |                            |                  |  |
| 14713  |  |  |  |  | 14721   |   |  |   |                            |                  |  |
| 1. DECEASED-NAME (Type or print)   |  |  |  |  | 2a. DATE OF DEATH   |   |  | 2b. HOUR  |                            |                  |  |
| John G. Moorhead   |  |  |  |  | October 1 Day 1968  |   |  | 1:00 P.M.   |                            |                  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR   |                            |                  |  |
| Male   |  | White  |  | May 24, 1895   |   | 73 YRS.   |  | MONTHS DAYS HOURS MIN.  |                            |                  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH  |  |   |                            |                  |  |
| Indiana  |  | U.S.A.   |  |  |   | Montgomery Md.  |  |   |                            |                  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |                            |                  |  |
| Silver Spring  |  |  | 805 New York Avenue  |  |   | Physicist   |  | Chemical  |                            |                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |   | 13d. INSIDE CITY LIMITS?   |   | 13e. STREET AND NUMBER     |                  |  |
| Md.  |  |  | Montgomery   |  | Sil. Spr.   |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 805 New York Avenue        |                  |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |  |   |                            |                  |  |
| George Moorhead  |  |  | Alice Vincent  |  |   |   |  |   |                            |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address   |   |  |   |                            |                  |  |
| Yes  |  |  | yes  |  | Mrs. Phila E. Dawson 3229 S. Keystone Ave. Ind., Indiana            |   |  |   |                            |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                            |                  |  |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |   |   |  |   |                            |                  |  |
| IMMEDIATE CAUSE (a) Cerebral Thrombosis  |  |  |  |  |   |   |  | 5 Hrs.  |                            |                  |  |
| 4339 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |   |   |  |   |                            |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |  |  |  |   |   |  |   |                            |                  |  |
| (b) Arteriosclerosis, Gen.   |  |  |  |  |   |   |  | 15 YRS.   |                            |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |   |  |   |                            |                  |  |
| (c)  |  |  |  |  |   |   |  |   |                            |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |  |   |   |  |   |                            |                  |  |
| 332X   |  |  |  |  |   |   |  |   |                            |                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |                            |                  |  |
|  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |   |                            |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |   |  |   |                            |                  |  |
|  |  | HOUR A.M. Month Day Year P.M. 19   |  |  |   |   |  |   |                            |                  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION  |   | Street or R.F.D. No.  |  | City or Town County State   |                            |                  |  |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |   |   |  |   |                            |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 1958, to 10/1, 1968, that (I) (we) last saw the deceased alive on 9/24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  |  |  |  |   |   |  |   |                            |                  |  |
| 22b. SIGNATURE   |  |  |  |  | DEGREE  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                            | 22c. DATE SIGNED |  |
| L.B. Snow M.D.   |  |  |  |  |   |   |  |   |                            | 10 Oct. 1968     |  |
| 22d. PHYSICIAN'S NAME (Type)   |  |  |  |  | 22e. ADDRESS  |   |  |   |                            |                  |  |
| L.B. Snow M.D.   |  |  |  |  | 7950 New Hampshire Ave. Sil. Spr. Md.                               |   |  |   |                            |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City or Town) (County) (State)   |  |   |                            |                  |  |
| Cremation  |  | 10-2-1968  |  | St. Lincoln Crematory  |   | Pr. Georges Maryland  |  |   |                            |                  |  |
| 24. FUNERAL DIRECTOR   |  |  |  |  | ADDRESS   |   | 25a. REC'D BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE |                  |  |
| J.W. Lee   |  |  |  |  | Sil. Spr. Md.   |   | DATE OCT 4 1968  |   | Charles Judge              |                  |  |
| Warner E. Pumphrey, Inc. 8434 Georgia Ave.   |  |  |  |  |   |   |  |   |                            |                  |  |

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1. *Journal of the American Medical Association*, 1990; 263: 1025-1028.

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Vital Department at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |          |  |  |
|---|--|--|--|--|--|--|--|----------|--|--|
| <div style="display: flex; justify-content: space-between;"> <span>14714</span> <span>14722</span> </div>   |  |  |  |  |  |  |  |          |  |  |
| <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>  |  |  |  |  |  |  |  |          |  |  |
| 1. DECEASED-NAME<br>(Type or Print)   |  |  | First <u>Kenneth</u> Middle <u>William</u> Last <u>Moroney</u>   |  |  | 2a. DATE KNOWN OF DEATH  |  | 2b. HOUR |  |  |
| 3. SEX <u>M.</u>  |  |  | 4. RACE <u>W.</u>  |  | 5. DATE OF BIRTH <u>1/19/1898</u>  |  | 6. AGE (In years last birthday) <u>70</u> YRS. |          | 2c. DATE PRONOUNCED DEAD   |  |
| 7a. BIRTHPLACE (State or foreign country) <u>Penn.</u>  |  |  | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <u>Montgomery</u>           |          | 10. CITY OR TOWN OF DEATH <u>Chesapeake</u>  |  |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5410 Grove Street</u>  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Lawyer</u>                               |  |  | 12b. KIND OF BUSINESS OR INDUSTRY <u>Partner</u>   |  |          | 13. CITY OR TOWN <u>Chesapeake</u>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD.</u>  |  |  | 13b. COUNTY <u>Montgomery</u>  |  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          | 13d. STREET AND NUMBER <u>5410 Grove Street</u>  |  |
| 14. FATHER'S NAME First <u>William</u> Middle <u>Moroney</u> Last <u>Muller</u>   |  |  | 15. MOTHER'S MAIDEN NAME First <u>Margaret</u> Middle <u>Muller</u> Last <u>Muller</u>   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>                 |  |          | 16b. SOCIAL SECURITY NO. <u>083-05-4423</u>  |  |
| 16c. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)  |  |  | 17. INFORMANT <u>MRS. RITA LLOYD MORONEY, WIFE, SAMEAS #13</u>   |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)                    |  |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  | IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u>  |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |          | Sudden   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  | (b) <u>Hypertensive Cardiovascular Disease</u>   |  |  | DUE TO, OR AS A CONSEQUENCE OF   |  |          | Years.   |  |
| (c)   |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |  | 4201   |  |          |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |          |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  | 21b. TIME OF INJURY Month, Day, Year <u>19</u> P.M.  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)              |  |          |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)   |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                                 |  |          |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |          |  |  |
| ACTUAL SIGNATURE <u>John S. Bell</u> M.D.   |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |          | 22b. DATE SIGNED <u>Oct 24, 1968</u>   |  |
| EXAMINER'S NAME (Type)  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |  | ADDRESS (Street, city, town, or county)  |  |          |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  |  | 23b. DATE <u>10-28-1968</u>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>                            |  |          | 23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Montgomery Co. Md.</u> |  |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016</u>  |  |  | 25a. REC'D BY REGISTRAR <u>Charles Judge</u>   |  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |          | DATE <u>OCT 30 1968</u>  |  |

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RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

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# CERTIFICATE OF DEATH

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |   |  |  |  |   |  |  |  |
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| 1. DECEASED NAME<br>(Type or print)  |  | First<br>Clara   |  | Middle<br>Martha  |  | Last<br>Morrison   |  | 2a. DATE OF DEATH<br>October Month 11 Day 1968 Year                                 |  | 2b. HOUR P.M.<br>10:45 M   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Negro   |  | 5. DATE OF BIRTH<br>11/28/95  |  |  |  | 6. AGE (In years<br>last birthday)<br>72 YRS.                                       |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                                     |  |
| 7a. BIRTHPLACE (State or foreign<br>country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>Montgomery Md.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Olney   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address)<br>Montgomery General Hospital |  | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)<br>housewife   |  |  |  | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased<br>admission) STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Silver Spring  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET AND NUMBER<br>15528 Bailey's Lane                                       |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>Arthur Lockman  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Martha Toogood  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)<br>no  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Records Address<br>Montgomery General Hospital, Olney, Md.  |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br><u>4109</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave<br>rise to immediate cause (a),<br>stating the underlying cause<br>last. (b) <u>Arteriosclerosis - Coronary</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>and General</u> |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>Immediate</u><br><u>years</u><br><u>years.</u> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>4201</u> <u>Broncho pneumonia</u>   |  |  |  |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING<br>CAUSES OF DEATH? <u>Yes.</u> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (At home, farm, street, factory,<br>OFFICE BUILDING, ETC.)                                |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1956</u> , 19 <u>  </u> , to <u>Oct 15</u> , 19 <u>68</u> , that (I) (we) last<br>saw the deceased alive on <u>Oct 14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the<br>causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><u>Richard A. Yates</u><br>DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  |   |  | 22c. DATE SIGNED<br><u>10/15/68.</u>   |  |   |  |  |  |
| 22d. PHYSICIAN'S<br>NAME (Type)<br>Richard A. Yates, M. D.   |  |  |  |   |  | 22e. ADDRESS<br>Old Baltimore Road, Olney, Md.                                       |  |   |  |  |  |
| 23a. BURIAL, CREMATION, ·<br>REMOVAL (Specify)   |  | 23b. DATE<br>10-18-68  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lincoln Memorial  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Suitland, Md.                      |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>Robert L. Snowden - Rockville, Md</u>   |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR<br>DATE OCT 21 1968   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                   |  |   |  |  |  |

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UNITED STATES

OFFICE OF THE SECRETARY OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

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|--|--|--|--|--|--|--|--|---|--|--|--|--|--|---|--|---|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>MONTGOMERY</u> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>KENSINGTON GARDENS NURSING HOME</u>  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u><br>d. STREET ADDRESS <u>10705 HAYES AVE.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First <u>NELLIE</u> Middle <u>B</u> Last <u>MORSE</u>   |  | <b>4. DATE OF DEATH</b><br>Month <u>10</u> Day <u>8</u> Year <u>1968</u> |  | <b>5. SEX</b><br><u>F</u>  |  | <b>6. COLOR OR RACE</b><br><u>W</u>                    |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><u>Dec 27 1889</u>  |  | <b>9. AGE (In years last birthday)</b><br><u>78</u> yrs.   |  | <b>IF UNDER 1 YEAR</b><br>Months <u>0</u> Days <u>0</u>   |  | <b>IF UNDER 24 HRS.</b><br>Hours <u>0</u> Min. <u>0</u> |  |  |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HW.</u>  |  |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>—</u>   |  |  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Boston MASS</u>   |  |  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A</u>  |  |   |  |   |  |  |  |  |  |
| <b>13. FATHER'S NAME</b><br><u>James Maguire</u>   |  |  |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>ANNIE GORVIN</u> |  |   |  |  |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) |  |   |  |   |  | <b>16. SOCIAL SECURITY NO.</b><br><u>NA.</u>                 |  | <b>17. INFORMANT</b><br><u>JOHN J. MORSE JR</u> Address <u># 2</u> |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROSIS - SEVERE</u><br>4409 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4500 DEHYDRATION</u> |  |  |  |  |  |  |  |   |  |  |  |  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>10 YRS</u>  |  |   |  |  |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)  |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |
| <b>20c. TIME OF INJURY</b><br>Hour <u>0</u> e.m. <u>19</u> p.m. <u>19</u>  |  |  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)   |  |  |  | <b>20f. (City or town)</b> (County) (State)  |  |   |  |   |  |  |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1957</u> <b>to</b> <u>10/8</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>10/17</u> , <b>and that death occurred at</b> <u>2 A.M.</u> , <b>from the causes and on the date stated above.</b>   |  |  |  |  |  |  |  |   |  |  |  |  |  |   |  |   |  |  |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Henry W. Stout</u> M.D.  |  |  |  |  |  |  |  |   |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> |  |  |  | <b>22b. DATE SIGNED</b><br><u>10/8/68</u>                 |  |   |  |  |  |  |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>Henry W. STOUT.</u>  |  |  |  |  |  |  |  |   |  | <b>22d. ADDRESS</b><br><u>10011 GEORGIA AVE SILVER SPRING MD</u>   |  |  |  |   |  |   |  |  |  |  |  |
| <b>23a. BURIAL</b> <u>Burial</u>   |  |  |  | <b>23b. DATE THEREOF</b><br><u>Oct 11, 1968</u>  |  |  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Gate of Heaven</u>  |  |  |  | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Silver Spring Md</u>   |  |   |  |   |  |  |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Wm J. Altman</u>   |  |  |  |  |  |  |  |   |  | <b>ADDRESS</b><br><u>4748 Wasebe. NW.</u>  |  |  |  | <b>25a. REC'D BY REGISTRAR</b><br><u>DATE OCT 10 1968</u> |  |   |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>J. Charles Judge</u> |  |  |  |

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) <b>Roger Sylvester Moss</b>   |  |  | 2a. DATE OF DEATH<br>Month <b>10</b> Day <b>8</b> Year <b>1968</b> |   |  | 2b. HOUR <b>7<sup>00</sup></b> M <b>A</b>  |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>white</b>   |  | 5. DATE OF BIRTH <b>1-4-00</b>  |  | 6. AGE (In years last birthday) <b>68</b> YRS.   |  |
| 7a. BIRTHPLACE (State or foreign country) <b>West Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>America</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <b>Montgomery</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH <b>Takoma Park</b>   |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Sanitarium Hosp</b> |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Self-employed</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate Broker</b>                                  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Montgomery</b>  |  | 13c. CITY OR TOWN <b>Silver Spring</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET AND NUMBER <b>706 Brantford</b>  |  | 14. FATHER'S NAME First <b>Joseph T</b> Middle <b>Moss</b> Last <b>Moss</b>                                    |  | 15. MOTHER'S MAIDEN NAME First <b>Mary C</b> Middle <b>Young</b> Last <b>Young</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>   |  | 16b. SOCIAL SECURITY NO. <b>578 46 8225</b>  |  | 17. INFORMANT <b>Hospital Records</b>   |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Wound by hostile pneumonia</b><br><b>4129</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>acute pulmonary edema</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>congestive heart failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerotic heart disease &amp; coronary insufficiency</b><br><b>2 years</b> |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>48 hours</b><br><b>72 hours</b><br><b>15 months</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                   |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/3</b> , 19 <b>68</b> , to <b>10/8</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/7</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE <b>H.W. Ireys M.D.</b> DEGREE <b>M.D.</b>   |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED <b>10/8/68</b>  |  |
| 22d. PHYSICIAN'S NAME (Type) <b>H.W. Ireys M.D.</b>  |  |  |  | 22e. ADDRESS <b>7105 Riggs Road, Lewisdale, Md.</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE <b>10/10/1968</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>Martinsburg W.Va.</b>                       |  |
| 24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Mt. Rainier, Md</b>  |  |  |  | 25a. REC'D BY REGISTRAR <b>OCT 14 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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*[Faint, illegible text, likely bleed-through from the reverse side of the page]*



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## CERTIFICATE OF DEATH

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|   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <i>Lillian</i>  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH<br>Month <i>10</i> Day <i>2</i> Year <i>1968</i>  |  |  | 2b. HOUR<br>M  |  |  |  |  |  |
| 3. SEX<br><i>Female</i>   |  |  | 4. RACE<br><i>white</i>  |  |  | 5. DATE OF BIRTH<br><i>4/21/83</i>  |  |  | 6. AGE (In years last birthday)<br><i>85</i> YRS.  |  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><i>Philadelphia Penna</i>  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br><i>Montgomery</i>  |  |  | Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><i>Holy Cross Hospital</i> |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><i>Maryland</i>  |  |  | 13b. COUNTY<br><i>Montgomery</i>   |  |  | 13c. CITY OR TOWN<br><i>Silver Spring</i>   |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  | 13e. STREET AND NUMBER<br><i>2406 Calverton Drive</i>            |  |  |
| 14. FATHER'S NAME<br><i>Carl August Erik</i>  |  |  | First Middle Last  |  |  | 15. MOTHER'S MAIDEN NAME<br><i>Sophia Ruppel</i>  |  |  | First Middle Last  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown)  |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT<br><i>Benjamin H. Munroe Jr.</i>  |  |  | Address<br><i>2722 Calverton Dr. Silver Spring</i>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Myocardial infarction</i><br><i>4109</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Extension of myocardial infarction</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Atherosclerosis</i> |  |  |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                     |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>4201</i>   |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                       |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <i>19</i>  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work  |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                               |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9-20, 1968</i> , to <i>10-1, 1968</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>Oct 1, 1968</i> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.                                      |  |  |  |  |  |   |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Edward J. Richards</i>   |  |  | M.D. DEGREE  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  |  | 22c. DATE SIGNED<br><i>Oct. 2 - 1968</i>   |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><i>EDWARD J. RICHARDS</i>   |  |  | 22e. ADDRESS<br><i>1011-GEORGETOWN AVE. SILVER SPRING</i>  |  |  |   |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>Oct 5 - 1968</i>  |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>St. Lincoln</i>  |  |  | 23d. LOCATION (City or Town) (County) (State)<br><i>Bladensburg Md. Prince Georges Md.</i> |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Arthur Walters</i>   |  |  | Address<br><i>294 Carroll St. N.W. Wash. D.C. 20012</i>  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <i>OCT 3 1968</i>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1973

MADE IN GERMANY

OCT 8 1973

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |                   |   |  |   |  |   |  |   |  |  |
|---|-------------------|---|--|---|--|---|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                   |   |  |   |  |   |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or Print) <i>Theresa Margaret Musgrove</i>  |                   |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>Oct</i> Day <i>6</i> Year <i>1968</i> |   |  | 2b. HOUR <i>6:20</i> PM   |  |   |  |  |
| 3. SEX <i>Fe</i>  | 4. RACE <i>W.</i> | 5. DATE OF BIRTH <i>Oct 4, 1880</i>   | 6. AGE (In years last birthday) <i>88</i> YRS.   | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____  | IF UNDER 24 HRS.<br>HOURS _____ MIN _____                              | 2c. DATE PRONOUNCED DEAD<br>Month <i>Oct</i> Day <i>6</i> Year <i>1968</i>              |  | 2d. HOUR <i>6:20</i> PM   |  |  |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>   |                   | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH <i>Montgomery</i> Md.  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH <i>Wheaton</i>  |                   |   | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wheaton Nursing Home</i>   |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>  |                   |   | 13b. COUNTY <i>Montgomery</i>  |   | 13c. CITY OR TOWN <i>Wheaton</i>                                       |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET AND NUMBER <i>1701 Arcola Ave.</i>   |  |
| 14. FATHER'S NAME First <i>R. Thomas</i> Middle <i>Sullivan</i> Last <i>Sullivan</i>  |                   |   |  | 15. MOTHER'S MAIDEN NAME First <i>Agnes F.</i> Middle <i>O'Donahue</i> Last <i>Sullivan</i>   |  |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>  |                   |   | 16b. SOCIAL SECURITY NO. <i>213-50-9191</i>  |   | 17. INFORMANT ADDRESS <i>J1 Edna Forsyth-same item + 13 - daughter</i> |   |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pulmonary Edema Acute</i><br><i>887X</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Arterio Sclerotic Heart Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>Generalized Arterio Sclerosis</i>  |                   |   |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>10 Days -</i><br><i>Years.</i><br><i>Years.</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><i>904.0 Compression Fracture of 12th Dorsal Vertebra</i>   |                   |   |  |   |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |                   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                   | 21b. TIME OF INJURY Month, Day, Year <i>5:20 P.M. Aug 16, 68</i>                            |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><i>Fell at home, injuring back.</i>                                      |  |   |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                   | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><i>Home</i> |  | 21f. LOCATION Street or R.F.D. No. <i>1701 Arcola St</i> City or Town <i>Wheaton</i> County <i>Montgomery</i> State <i>Md.</i>                              |  |   |  |   |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                   |   |  |   |  |   |  |   |  |  |
| ACTUAL SIGNATURE <i>John G. Ball</i>  |                   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  | 22b. DATE SIGNED <i>Oct. 6, 1968</i>  |  |   |  |  |
| EXAMINER'S NAME (Type) <i>John G. Ball</i>  |                   | 7936 Old Georgetown Road, Bethesda, Md.   |  |   |  |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>   |                   | 23b. DATE <i>10/9/68</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY <i>St. Johns Cemetery</i>  |  |   | 23d. LOCATION (City or Town) (County) (State) <i>Forest Glen, Montg. Md.</i>                 |   |  |  |
| 24. FUNERAL DIRECTOR <i>Tyson Wheeler Funeral Home</i>  |                   |   |  | 1311 Rock. Pike Rockville, Md.  |  |   | 25a. REC'D BY REGISTRAR<br>DATE <i>OCT 8 1968</i>  |   | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>  |  |

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